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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

H.R. 2990/H.R. 3566

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES, FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1990, AND FOR OTHER PURPOSES

Part 4 (Pages 1-877)

Nondepartmental witnesses

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

THURSDAY, MAY 11, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:40 a.m., in room SD–116, Dirksen Senate Office Building, Hon. Brock Adams presiding.

Present: Senators Adams and Specter.

NONDEPARTMENTAL WITNESSES

Senator ADAMS. Good morning. I am Senator Brock Adams, and I will be chairing the hearings this morning.

I will apologize in advance. At 10:45 there is a swearing-in on an impeachment matter so that all Senators have to go to the floor to be sworn in. This is on a Federal district judge, not the Federal district judge that is being tried now, but on another one who had a little problem. So, I will go over to that, and then I will immediately return.

I mention that because we are going to try very hard that everyone be heard today because you see this morning is the fifth of 6 days of public witness testimony focusing on the programs of the Subcommittee on Labor, Health and Human Services and the 17 related agencies.

During these several sessions, the subcommittee will hear testimony from approximately 150 witnesses. Now, it is a matter of some regret to all of us on the subcommittee that we have had to limit the number of witnesses this year because we like to hear everybody if we possibly can. You have all been very understanding, and I want to express my appreciation and that of Senator Kennedy and all the other members of the committee for your taking the time in coming to be with us and to testify. You have been very understanding about the time constraints.

I do want to assure you that witnesses who have their testimony to the subcommittee staff by May 15—that's by May 15—will have that testimony put into the hearing record so that you don't have to say everything orally. I will be pleased to put your statements in in full. You will have that many more days to add to them.

In order to keep us on schedule, you will see we have the red/green light system, and most of you are familiar with it from many times in the past. As you know, each witness has 3 minutes in which to present his or her oral testimony. When the red light goes on, your 3 minutes have expired. We need to ask each of you to conclude your remarks when the red light goes on so that each of the other witnesses will have a fair and equal opportunity to be heard.

I would like to welcome all of you to the committee this morning. Today's hearing begins with mental health issues, and our first witness is Dr. James Egan from the Children's Hospital's Department of Psychiatry. Welcome, Dr. Egan. We are prepared to hear your testimony and please proceed.

If each witness will let me know as they start whether they wish to summarize, have their statement put in in full, or handled in another manner, I will rule on that at the time that you start.

STATEMENT OF JAMES EGAN, M.D., CHAIRMAN, DEPARTMENT OF PSYCHIATRY, CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER AND THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Senator Adams. Dr. Egan, welcome and we are pleased to have you here this morning.

Dr. Egan. Thank you very much, Senator and members of the committee. I would ask that my full testimony be submitted into the record and I will be mercifully brief and just summarize.

Senator Adams. Without objection, the entire statement will appear in the record as though read.

Dr. Egan. I represent the Academy of Child and Adolescent Psychiatry, and we join other members of the mental health community to urge support for the following levels of funding for NIMH programs for fiscal year 1990, specifically for research, $502 million, up from the $306 million recommended by the President's budget; for research training, $43 million, up from $20 million recommended by the President's budget; and $26 million for clinical training, up from $7 million recommended by the President's budget.

Research is the single most important function of ADAMHA and the NIMH. And with an appropriation of $502 million, NIMH will be able to implement recommendations from the national plans published in 1988 for schizophrenia and neurosciences research.

With $43 million for research training, we would be able to support the development of a critical mass of scientists to engage in clinical and basic research.

For many years research into mental illness of children and adolescents has lagged behind because of a paucity of trained research scientists now prompted by the 1984 Institute of Medicine study in which a severe limitation in research manpower was noted. They have asked for a new study of child and adolescent mental health disorders and research.

Through research we will be better able to understand and treat depression, substance abuse, eating disorders, developmental disorders in infancy, attention deficit disorders, and other areas such as posttraumatic stress syndrome in children and adolescents.

PREPARED STATEMENT

If I may make one parenthetical comment. When I say attention deficit disorder, it sounds somewhat benign. It afflicts 4 percent of all males, and one-third of those at 18 years of age will have either a felony conviction or a serious substance abuse problem without adequate treatment.

In closing, we strongly encourage you to fund at a full appropriation of $502 million the amounts requested by the various mental health agencies.

Thank you very much.

Senator ADAMS. Thank you, Doctor. I have just one question as we go to the next one, and I will not necessarily be asking all witnesses questions. But, Doctor, I just want to leave this thought with you.

I am on both the authorizing committee and the Appropriations Committee that involves this particular area of the Government. I also happen to, fortunately or unfortunately, be chairman of the Subcommittee on the District of Columbia. One of our significant problems—and I hope that you will submit some written testimony on this—is research and suggestions into the manner of both detoxifying and treating or holding for substantial periods adolescents in particular that are afflicted with crack addiction.

One of the primary complaints that I am hearing in various cities, as I travel through them, is that there is no known cure, that there is really not a—when I say no known cure, there is nothing magic—and second, that holding problems are extraordinarily difficult because the substance is new, it has differing effects. We are faced with a great deal of violence and with a real necessity for knowing where we place these people once they may be picked up from the street. I'm sure you are aware of the homicides we had here and the violence, and we simply do not know enough about this.

Dr. EGAN. I think you have eloquently stated the need for research into the basic mechanisms and demonstration projects and training initiatives which try and prevent and treat these disorders.

Senator ADAMS. We appreciate very much your testimony. I mention that to you because it is one that I have made requests directly to the National Institutes of Health and you happen to be in that particular area.

Dr. EGAN. Thanks very much.

Senator ADAMS. Thank you for your testimony very much, Dr. Egan.

[The statement follows:]

STATEMENT OF JAMES EGAN

The American Academy of Child and Adolescent Psychiatry appreciates this opportunity to testify before the Subcommittee on the President's 1990 budget request for the National Institute of Mental Health.

I am James Egan, M.D., Chairman of the Department of Psychiatry at Children's Hospital National Medical Center and member of the American Academy of Child and Adolescent Psychiatry. I am here today to thank the members of the Subcommittee for their past support of NIMH research, training and service programs. I also urge, not only continued support, but expansion for programs that exhibit leadership in research and training, and technical assistance for mental health service programs.

The national direction for mental illness research, training and services is developed through the National Institute of Mental Health. The results of this leadership flow into the state and local governments and research programs throughout the country. Without strong federal support, all levels of research and treatment services diminish, and too often children and adolescents are the first to lose their opportunity for treatment.

The American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry is a national, professional association of over 4300 child and adolescent psychiatrists. Its members are physicians who have completed a general psychiatry residency and two years residency training in child and adolescent psychiatry. This medical discipline is concerned with the prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and their families. These disorders include depression, attention deficit disorders and learning disabilities, schizophrenia, substance abuse, eating disorders, suicide and conduct disturbances. The number of children and adolescents with mental illnesses has not declined. We still look at a prevalence rate of approximately 11 percent, or over 7 million youngsters under age 18 who need help at any given time. Serious mental disorders affect 2 to 3 million children and adolescents, with an estimated two-thirds not receiving appropriate treatment.

While the number of child and adolescent psychiatrists grows by about 250 each year, the number of children and adolescents with serious emotional disorders continues to far outreach the capacity of those who are trained to treat them. In 1980, the Graduate Medical Education Advisory Committee reviewed the requirements for treating psychiatrically ill children and adolescents in this country and recommended that a range of 8,000 to 10,000 child psychiatrists would be needed by 1990.

For all our efforts, we will fall far short of that number, which brings me here today to ask for your help in supporting research into the causes of mental illness, training the professionals who treat those illnesses, and assisting communities to develop a full continuum of services for the mentally ill.

Appropriations Recommendations

The Academy joins with other members of the mental health community to urge support for the following levels of funding for NIMH programs in FY 1990:

Research	$502.1 million
Research training	43.6 million
Clinical training	26.0 million

Mental Health Services Demonstrations......$38.3 million with a specific recommendation for the Child and Adolescent Services System Program (CASSP) of $9.8 million.

The Academy supports funding for the Alcohol, Drug Abuse and Mental Health Administration block grant at $918.6 million; for the mental health prevention services demonstration program, $10 million; and for the protection and advocacy program for the mentally ill, $22 million.

Research and Research Training

Research is the single most important function of the Alcohol, Drug Abuse and Mental Health Administration in general, and the National Institute of Mental Health in particular. With an appropriation of $502.1 million, NIMH will be able to implement recommendations from the national plans published in 1988 for schizophrenia research and neurosciences research. With $43.6 million designated for research training, NIMH would be able to support the development of a critical mass of scientists to maintain progress through research. The President's budget calls for only $20.3 million for research training FY 1990, an amount that will not cover current programs and will mean no growth in this critical training area.

The requested increase to $502.1 million is also significant for child and adolescent psychiatry. For many years, research into the mental illnesses of children and adolescents has lagged behind because of a lack of trained research scientists and adequate funding. Now, prompted by the 1984 Institute of Medicine report on mental illness, which noted the "severe limitations in manpower and resources..." in research on childhood and adolescent disorders, the NIMH has asked IOM to look specifically at these limitations in a major "Study of Child and Adolescent Mental Disorders Research."

The child and adolescent psychiatry research community is encouraged by this study. Its recommendations will be welcomed as a plan for a national initiative. With adequate funding we can address childhood disorders and better understand those adult mental illnesses that have their origins in childhood. Through research we will be better able to understand and treat depression, substance abuse, eating disorders, developmental disorders in infancy, attention deficit disorders, and new areas such as post-traumatic stress syndrome in children and adolescents. The possibilities are endless and the results could drive major advances in treatment.

The $502.1 million requested is a significant increase over the $293.5 million FY 1989 appropriation; however, at least $314 million will be needed to continue ongoing projects, and the President's budget requests only $306 million. Implementing three major national research plans warrants an increase in appropriations commensurate with the enormous importance of the research that is and will be taking place.

The Academy recommends an FY 1990 appropriation for the NIMH research and research training programs of $502.1 million.

Clinical Training

The President's budget asks for $7.5 million for the NIMH clinical training program. While this program continues to be an important source of training for serving persons with mental illnesses, the drastic reductions in funding, down from over $70 million each year in the 1970s, have intensified the shortage of mental health professionals. The hope that states would provide the difference in the funding as the federal dollars were reduced has not been realized.

Congress generously supported the clinical training program during 1982 - 1987 when the President's budget called for zero-based budgeting. Congress also used foresight to specify language giving priority to training for underserved populations such as child and adolescent training programs. But each year the number of continuing grants has become smaller and fewer new grants are funded. At $7.5 million, no new grants would be funded, and the President's requested three-year phase out plan would be realized.

An appropriation of $26 million would allow clinical training programs to improve and expand training and support placement in shortage areas and in public facilities. The grants promote better quality training at both community and university-based training sites, and they allow faculty members to expand the curricula into family services, minority programs, and special areas such as substance abuse.

The Academy recommends an FY 1990 appropriation for the NIMH clinical training program of $26 million.

Child and Adolescent Service System Program

The Academy has supported the NIMH Child and Adolescent Service System Program (CASSP) since its inception in 1984. CASSP is a strategy development program to improve systems for service delivery to severely emotionally disturbed children and adolescents. The primary goal is to change the way services to this population are delivered by states and communities.

In 1982, only seven states had any system for coordinating child and adolescent mental health services. Beginning with $1.5 million the first year and then averaging about $5 million per year, CASSP has developed new strategies for coordinating service systems and an impressive technical assistance program, minority initiative, family support program, and special high-risk program for homeless children and adolescent and children at risk for HIV infection.

By FY 1989, forty states and thirteen communities had received grants to devise and implement a service system program within their jurisdictions. Last September, the first 10 CASSP grants finished the five year development process. It is already apparent that the evaluations will show this to be an efficient and effective use of federal funds. The official evaluations will provide data for a valuable study of system development strategies.

The President's budget requests $19 million for all of the mental health demonstration programs, which is far short of the $27.3 million needed to support current services. If Congress appropriates the $38.3 million recommended by the Academy and other organizations, a designation of at least $9.8 million for CASSP will allow the remaining state and community grants to continue. The Administration has also asked for a three-year phase over to state funding for CASSP. This request does not recognize the advantages of having a central source for technical assistance, for high-risk program coordination, and for evaluation and data collection. Without the NIMH CASSP program, valuable information could be lost -- information that determines which service system programs are the most efficient and provide the best continuum of care for severely emotionally disturbed children and adolescents.

The Academy recommends an FY 1990 appropriation for mental health demonstration programs at $38.3 million, with a designation of $9.8 million for the Child and Adolescent Service System Program.

Summary

The American Academy of Child and Adolescent Psychiatry urges even greater support for mental illness and substance abuse programs as they work side by side to address a growing list of national priorities -- homelessness, AIDS, health care for uninsured or underinsured families, and access to a continuum of health care services. Children and adolescents should come first on that list and strong NIMH research, training and services will give those with psychiatric disorders a better chance for early diagnosis and effective treatment.

Thank you again for allowing me this time to testify.

STATEMENT OF CAROL GARVIN, PRESIDENT, NATIONAL MENTAL HEALTH ASSOCIATION

Senator ADAMS. Our next witness will be Carol Garvin, National Mental Health Association. Ms. Garvin, welcome to the committee.

Ms. GARVIN. Thank you. And I also ask that our testimony be entered in full, and I will summarize.

Senator ADAMS. Without objection, it is so ordered. It will be entered in full, and we are prepared to hear your testimony.

Ms. **Garvin**. Thank you, Senator. I am honored to speak on behalf of the Mental Health Association and our membership in Washington and my State of South Carolina and the chairman's State of Iowa and across the country.

We regard the decisions of this subcommittee as absolutely essential to that one-fifth of the population who have a legitimate need for psychiatric treatment and related services. As you know, those people include people who are homeless, people who suffer from the most serious mental illnesses, people in our rural communities, children, the elderly, and people who have both a mental illness and an addictive disorder. We have a sense of who those people are and what they need, and we must have major increases in research funding so that we can get at the causes of these mental illnesses. The research is very promising. It is a wonderful time to invest in it.

I have been a volunteer in the Mental Health Association for 14 years working locally in the State and national levels. I have friends who have been mentally ill for much longer than that, and some of them are finally better because of their diagnoses and because of treatment and their own courage. But for all of them, they have been through great pain and fear and isolation and they must have hope, and research brings hope.

However, in our view it is cruel to talk about major increases in funding for research unless we also have major increases in service demonstration. We have to find effective ways to respond to people in their practical needs for response to their mental illnesses. We do have development models of community service which are working effectively for many people. We also have the new opportunity in the protection and advocacy legislation which is providing services across the country for people who have need for protection, but we have to have major increases in this endeavor as well.

PREPARED STATEMENT

I want to speak in particular among those people that we care about, the people who do have the dual diagnosis of mental illness and substance abuse and also children. We have 12 to 15 percent of our younger generation who are affected by emotional disorders and we have to respond to them. We know that the mental illnesses are illnesses of the brain and the brain is an organ of the body. We have to begin responding to those illnesses as we do to other illnesses. So, we beg for your effective response.

Thank you.

Senator **Adams**. Thank you, Ms. Garvin, very much for your testimony. It will be include in full, and we appreciate your being here with us this morning.

[The statement follows:]

STATEMENT OF CAROL GARVIN

Mr. Chairman, my name is Carol Garvin and I am the President of the National Mental Health Association, a private, voluntary organization providing leadership to confront the entire range of mental health issues at local, state and national levels.

I have been involved in the field of mental health for some time now. Over the years I have seen significant changes and improvements in the treatment and care of persons with mental illness, as well as dramatic increases in our understanding of how the brain functions. However, Mr. Chairman, we still have a long way to go. Consider these facts:

- 1 out of every 5 adults in the U.S. suffers from a diagnosable mental disorder. Yet only 20 % of those with mental disorders receive treatment.

- At least 12% of the nation's children are in need of some type of mental health treatment, but 70-80% do not receive appropriate mental health services.

- In 1985, the estimated total cost of mental illness to the U.S. was $114 billion -- more than $38 billion for direct treatment and support, and the rest for indirect costs including lost productivity, increased physical illness, and death through suicide.

Children with mental and emotional disorders are one of our most vulnerable, and most underserved populations. The impact of childhood emotional disorders is considerable. From a clinical perspective, these disorders often have a devastating impact on the child's personal, cognitive and social development as well as their impact on family and society. From a public health standpoint, the burden of illness in children and adolescents has become associated with tragic consequences such as drug and alcohol abuse, educational and social dysfunction and suicidal behavior.

Very little is known about child and adolescent disorders, and relatively little current research attention is devoted to them. However, recent technological breakthroughs indicate that it is an opportune time to advance knowledge about these illnesses. We recommend increased attention to the needs of children in all NIMH programs.

Research

Mr. Chairman, it is clear that expanded research is imperative to find the key to the causes, treatment, and cure for mental illnesses for all populations. The field is explosive with promise. For example, we hope to learn in the foreseeable future how the disposition to mental illness is transmitted and the biological basis of inherited factors. Schizophrenia, bipolar affective disorders, alcoholism and panic disorders, which are among the most numerous and most costly of the mental illnesses, are the most strongly implicated in hereditary transmission. Once we determine how these illnesses are inherited, we will be that much closer to being able to prevent them.

For the first time in history we have the tools to learn how to reverse addiction. Spectacular advances in molecular and cellular biology have made it possible to define the basis of addiction. This is especially exciting given that approximately 50% of persons with chronic mental illness are substance abusers as well. Therefore, research on mental illness is directly implicated with substance abuse, which is directly linked to the transmission of AIDS. It is clear that the results of research on the brain will have a wide-reaching effect-- possibly providing us with solutions to the problems of addiction and AIDS.

Of all the mental disorders, those of the aged are among the most prevalent, the most devastating, and the most difficult to treat. Five percent of the elderly suffer from senile dementia, the principal form being Alzheimer's disease. The pace of progress in research on Alzheimer's disease has been rapid, a trend that should continue. NIMH is exploring the genetic basis of this disease and the use of biological and behavioral techniques to improve memory. NIMH is also developing family care and service delivery models to reduce the stress and burden of family members who care for an Alzheimer's disease patient.

According to the Institute of Medicine, the personal and social costs of alcohol, drug, and mental disorders are comparable to those for heart disease or cancer -- approximately $1000 per year for every man, woman, and child in the U.S. But in FY 1988, the per capita Federal commitment to research on these disorders was only about $1.80. How can we rationalize this lack of funding when, for example, the development and use of lithium as a treatment for manic-depressive illness saved the U.S. an estimated $4 billion during a 10-year period --$2.8 billion in treatment costs and another $1.2 billion in increased productivity? The discovery of carbamazepine as a therapy for lithium-resistant manic-depression is expected to save an additional $1 billion to $4 billion.

Services

I would like to address at this point the mission of the NIMH. The NIMH engages in a far reaching scope of activities among which are research, treatment and service system development. As I have previously stated, research is crucial to enhancing our understanding of the cause and treatment of mental illnesses. However, the application of research findings to clinical practice and service settings is the primary means to justify funding of basic research. We must acknowledge the interdependent relationship between research and services.

Mr. Chairman, another issue which greatly concerns me is the number of homeless people in this country, which is reaching epidemic proportions. The homeless population is a very diverse one which is comprised of families, children, veterans, minorities and even employed individuals. This new social epidemic is a tragic waste. Our cities are turning into new Calcuttas as a result of the rapidly increasing number of homeless persons. As you know, approximately 1/3 of these individuals have a mental illness. Some had a mental illness prior to becoming homeless, while others developed an illness following a period of homelessness.

According to the Congressional Budget Office, it is expected to cost $38 billion to bail out the ailing Savings and Loan industry. If our nation can afford to expend this amount to save the S&L's, we can afford not only to fulfill our responsibility to provide the multiple services needed by people who are already homeless, but also to insure that services are provided so that others do not become homeless as well. We recommend, Mr. Chairman, full funding of McKinney Act programs and additional resources for mental health services for persons who are homeless.

Funds for the Protection and Advocacy System for persons with mental illness are provided to states on a formula grant basis to protect and advocate for persons with mental illness and to investigate incidents of abuse and neglect in mental health facilities. These programs represented approximately 10,000 clients in 1988, its first full year of operation.

The establishment of this program has demonstrated the critical need for advocacy services for a neglected population, yet the Administration has requested a cut in this program. NIMH Director Lewis Judd has used the rationale that the program was originally envisioned as a federal start-up program, with the responsibility then to be turned over to the states once the program was underway. This was not, however, the intent of the original authorizing legislation. Given the financial dilemmas which currently exist in the states, if they are required to pick up the tab, these desperately needed programs will fall to the wayside. We therefore request an increase in funding to $22 million.

We must also address the issue of the mental health of rural Americans. The 1980's have been very difficult for Americans in rural communities who have been stressed by rapidly changing economic and social factors. Between 1981 and 1983, rural America lost 500,000 jobs. Twenty-five percent of the U.S. population lives in rural areas, but 38 percent of the people who live in poverty live in rural areas; 67 percent of the nation's substandard housing is found in rural areas; and the unemployment rate is 50 percent higher in rural areas. It is our recommendation that the NIMH should increase the levels of funding directed to support research on the mental health of rural Americans, as well as increasing funding for clinical training programs that focus on treatment in rural areas.

As you know, Mr. Chairman, the NIMH Services Demonstration program focuses on the unique problems of persons with severe, long-term mental illness residing in the community.

This program has proven to be highly effective since its inception. We recommend an increase in this program to $38.3 million in order for the continuation of existing programs, and to adequately fund new projects for the new populations being served under this program, particularly substance abusers.

As part of the Omnibus Drug Bill which was passed last Fall, Congress authorized a new mental health services demonstration program so that prevention services might be provided to individuals who are at risk of developing a mental illness. These programs would put into practice what research has already shown to be effective, and would prove to be cost-effective since they address potential mental health problems before long-term services are required. We are requesting that Congress fund this program at $5 million.

While we empathize with the Fiscal Year 1990 budget constraints, we ask you to remember and continue your focus on the needs of persons with mental illness as you appropriate funds for the coming year. It is impossible to emphasize too strongly the critical need for an increase in research and the provision of services for this population. I began my testimony by stating that the mental health field is explosive with promise. In order to see this promise fulfilled, we must, in the words of this Committee, make expanded research activity, as well as service delivery, a high priority for the Nation.

STATEMENT OF JOHN S. GUSTAFSON, FIRST VICE PRESIDENT, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

Senator **Adams**. Our next witness will be Mr. John S. Gustafson, National Association of State Alcohol and Drug Abuse Directors. Mr. Gustafson, welcome to the committee. We are pleased to see you this morning.

Mr. **Gustafson**. Good morning, Senator. I am pleased to join you this morning. Thank you for the invitation to present testimony on behalf of the National Association of State Alcohol and Drug Abuse Program Directors.

NASADAD is a not-for-profit organization whose membership is exclusively made up of the State and territorial officials designated by the Governors to administer publicly funded alcohol and drug abuse treatment and prevention systems.

Across our Nation drug abuse and alcohol problems continue to grow in magnitude and severity, particularly among our youth. States and local communities throughout the country have a significant and growing need for additional Federal resources for alcohol and other drug abuse prevention and treatment services.

Examples of the increasing devastation caused by these problems include the following. During 1988, intravenous drug use was associated with 33 percent of the AIDS cases reported for the year, and with an ever higher proportion of AIDS cases among women, approximately 80 percent minorities and children. Every year more and more babies are born addicted to cocaine and other drugs. There is a continuing trend from prior years. Cocaine treatment admissions rose over 50 percent from fiscal year 1987 to fiscal year 1988 from approximately 85,000 admissions in 1987 to over 138,000 admissions in 1988.

Alcohol continues to be the No. 1 drug abuse singly or in combination with other drugs. Of the 1.7 million admissions to publicly funded treatment programs, approximately 1.2 million were admitted for primary alcohol problems.

Currently, the alcohol, drug abuse, and mental health services block grant provides less than one-third of the moneys contributed by State and local governments for alcohol and other drug abuse services. Last year, a total of $2.1 billion was spent for State-supported alcohol and drug abuse prevention treatment services. Of that total, State funding provided for 57.4 percent. ADTR and other block grant moneys contributed 16.5 percent.

With the funding provided to State alcohol and drug abuse agencies last year, a total of 6,916 alcohol and other drug abuse treatment facilities were funded, and over 1.7 million clients were admitted to alcohol and other drug abuse treatment services.

Unfortunately, the administration's 1990 budget request of $800 million for the ADMS block grant represents a $5 million reduction. If this reduction of funds is applied to ADMS services, this would seriously impede the States' ability to continue the alcohol and drug abuse treatment and prevention services that have been implemented due to the increased funding.

Due to the escalating unmet treatment needs of substance abusers, including the alarming increase of AIDS among IV drug abusers and the growing crack-cocaine epidemic, NASADAD respectfully requests that the members of the appropriations subcommittee seriously consider appropriating a much higher amount for the ADMS block grant. Specifically, we recommend that $1.6 billion be appropriated for fiscal year 1990.

Several factors recently have contributed to the manner in which the States use the ADMS moneys. First of all, the ADMS and mental health block grant funds are available to States on what is called a drawdown basis that permits funds to be taken from the Federal treasury a maximum of only 2 to 3 days before a State writes checks to reimburse community programs for services.

There has been a lot of negative publicity, Senator, recently in the press that the States have, in fact, not been accessing these moneys as expeditiously as possible. This is not the case. In fact, what happens in practice is the States use these Federal funds to reimburse themselves. The drawdown terminology is really an artifact. The moneys have, in fact, been committed, programs have expanded, people have been admitted to services, and the moneys are being utilized for the purposes for which the Congress has made them available.

All States implement a careful and deliberate planning process in order to ensure that these moneys are utilized in a cost-effective manner where they are most needed. Mr. Chairman, pleased be assured that the States and local governments are, indeed, using these funds as wisely and expeditiously as possible.

We look forward to a continued and strengthened partnership with the Congress and the administration to target more Federal resources to alcohol and other drug treatment and prevention services.

PREPARED STATEMENT

We have attached to our testimony some additional detailed justifications for our request, and we would ask that they would be admitted to the record.

Senator ADAMS. Without objection, it will be so ordered.

[The statement follows:]

STATEMENT OF JOHN S. GUSTAFSON

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO ADDRESS THE PRESIDENT'S FISCAL YEAR 1990 BUDGET REQUEST FOR FEDERAL ALCOHOL AND OTHER DRUG ABUSE PROGRAMS.

MY NAME IS JOHN GUSTAFSON. I AM DEPUTY DIRECTOR OF THE DIVISION OF SUBSTANCE ABUSE SERVICES FOR THE STATE OF NEW YORK AND AM APPEARING BEFORE YOU TODAY AS THE FIRST VICE PRESIDENT OF THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS (NASADAD). NASADAD IS A NOT-FOR-PROFIT ORGANIZATION WHOSE MEMBERSHIP IS COMPRISED EXCLUSIVELY OF THE STATE AND TERRITORIAL OFFICIALS DESIGNATED BY THE GOVERNORS TO ADMINISTER THE PUBLICLY FUNDED ALCOHOL AND DRUG ABUSE TREATMENT AND PREVENTION SYSTEM.

CONTINUING NEED FOR ADDITIONAL FEDERAL RESOURCES FOR THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT

ACROSS OUR NATION DRUG ABUSE AND ALCOHOL PROBLEMS CONTINUE TO GROW IN MAGNITUDE AND SEVERITY, PARTICULARLY AMONG OUR YOUTH. STATES AND LOCAL COMMUNITIES THROUGHOUT THE COUNTRY HAVE A SIGNIFICANT AND GROWING NEED FOR ADDITIONAL FEDERAL RESOURCES FOR ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES.

EXAMPLES OF THE INCREASING DEVASTATION CAUSED BY THESE PROBLEMS INCLUDE THE FOLLOWING:

- DURING 1988 INTRAVENOUS DRUG ABUSE WAS ASSOCIATED WITH 33.3 PERCENT OF THE AIDS CASES REPORTED FOR THE YEAR, AND WITH AN EVEN HIGHER PROPORTION OF AIDS CASES AMONG WOMEN (APPROXIMATELY 80 PERCENT), MINORITIES AND CHILDREN;
- EVERY YEAR MORE AND MORE BABIES ARE BORN ADDICTED TO COCAINE AND OTHER DRUGS;
- CONTINUING A TREND FROM PRIOR YEARS, COCAINE TREATMENT ADMISSIONS ROSE BY OVER 50 PERCENT FROM FISCAL YEAR (FY) 1987 TO FY 1988, FROM APPROXIMATELY 85,000

ADMISSIONS IN FY 1987 TO OVER 138,000 ADMISSIONS IN FY 1988.

- ALCOHOL CONTINUES TO BE THE NUMBER ONE DRUG OF ABUSE, SINGLY OR IN COMBINATION WITH OTHER DRUGS. OF THE 1.7 MILLION ADMISSIONS TO PUBLICLY FUNDED TREATMENT PROGRAMS, APPROXIMATELY 1.2 MILLION WERE ADMITTED FOR PRIMARY ALCOHOL PROBLEMS.

CURRENTLY THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES (ADMS) BLOCK GRANT PROVIDES LESS THAN ONE-THIRD OF THE MONIES CONTRIBUTED BY STATE AND LOCAL GOVERNMENTS FOR ALCOHOL AND OTHER DRUG SERVICES. LAST YEAR, A TOTAL OF OVER $2.1 BILLION WAS SPENT FOR STATE SUPPORTED ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SERVICES. OF THE TOTAL, STATE AND LOCAL FUNDING ACCOUNTED FOR 57.4 PERCENT AND THE ADMS AND ADTR BLOCK GRANTS PROVIDED 16.5 PERCENT OF THE TOTAL. THE REMAINING FUNDS CAME FROM OTHER SOURCES, INCLUDING THIRD-PARTY REIMBURSEMENT AND CLIENT FEES.

WITH THE FUNDING PROVIDED TO THE STATE ALCOHOL AND DRUG ABUSE AGENCIES LAST YEAR, A TOTAL OF 6,916 ALCOHOL AND OTHER DRUG ABUSE TREATMENT FACILITIES WERE FUNDED AND OVER 1,734,000 CLIENTS WERE ADMITTED TO ALCOHOL AND OTHER DRUG ABUSE TREATMENT. ADDITIONALLY, HUNDREDS OF THOUSANDS OF CHILDREN AND ADULTS PARTICIPATED IN ALCOHOL AND OTHER DRUG ABUSE PREVENTION PROGRAMS DEVELOPED BY THE STATES AND LOCAL COMMUNITIES THROUGHOUT THE COUNTRY.

THE ADMINISTRATION'S FY 1990 BUDGET REQUEST OF $800 MILLION FOR THE ADMS BLOCK GRANT REPRESENTS A $5 MILLION REDUCTION. IF THIS REDUCTION IN FUNDS IS APPLIED TO ALCOHOL AND DRUG ABUSE SERVICES, THIS WOULD SERIOUSLY IMPEDE THE STATES' ABILITIES TO CONTINUE THE ALCOHOL AND OTHER DRUG ABUSE TREATMENT AND PREVENTION SERVICES THAT HAVE BEEN IMPLEMENTED DUE TO INCREASED FUNDING MADE AVAILABLE BY BOTH THE 1986 AND 1988 ANTI-DRUG ABUSE LAWS.

FUNDING INCREASES ARE ESSENTIAL TO MAKE MORE TREATMENT SLOTS AVAILABLE TO INTRAVENOUS DRUG ABUSERS TO REDUCE THE ESCALATING AIDS/HIV RATE AMONG THIS POPULATION. THROUGH THE 1988 ANTI-DRUG ABUSE ACT, AN ADDITIONAL $125 MILLION IN FY 1989 BLOCK GRANT FUNDING WAS MADE AVAILABLE TO THE STATES WITH THE STIPULATION THAT ONE-HALF ($62.5 MILLION) BE SPENT FOR TREATMENT OF IV DRUG ABUSERS. THIS AMOUNT WAS VIEWED AS AN INITIAL DOWN PAYMENT TOWARD THE GOAL OF MEETING "TREATMENT ON DEMAND" AS RECOMMENDED BY THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS (AIDS) EPIDEMIC.

DUE TO THE ESCALATING UNMET TREATMENT NEEDS OF SUBSTANCE ABUSERS, INCLUDING THE ALARMING INCREASE OF AIDS AMONG IV DRUG ABUSERS AND THE GROWING CRACK/COCAINE EPIDEMIC, NASADAD RESPECTFULLY REQUESTS THAT THE MEMBERS OF THE APPROPRIATIONS SUBCOMMITTEE SERIOUSLY CONSIDER APPROPRIATING A MUCH HIGHER AMOUNT FOR THE ADMS BLOCK GRANT. SPECIFICALLY, WE RECOMMEND THAT $1.6 BILLION BE APPROPRIATED FOR FY 1990.

IMPACT OF THE 1988 ANTI-DRUG ABUSE ACT

WHEN CONGRESS REAUTHORIZED THE ADMS BLOCK GRANT LAST OCTOBER, A NEW ALLOCATION FORMULA WAS ADDED WHICH CHANGED THE DISTRIBUTION OF FUNDS AMONG THE STATES. WHILE SEVERAL LARGE, MORE URBAN STATES SAW FUNDING INCREASES, MANY STATES DISCOVERED THAT THEY WOULD ONLY RECEIVE LEVEL FUNDING OR ACTUALLY DECREASES IN FUNDING. A FEW STATES STAND TO LOSE UPWARD TO 10 PERENT OF THEIR FEDERAL MONIES IN FY 1989 AND UP TO 36 PERCENT BY FY 1993. ADDITIONALLY, STATES STILL AREN'T CERTAIN OF THEIR FY 1989 ALLOCATIONS BECAUSE THE TECHNICAL CORRECTIONS BILL RECENTLY PASSED IN THE SENATE WOULD CHANGE THE FORMULA ONCE AGAIN.

OTHER CHANGES IN THE BLOCK GRANT, INCLUDING THE NEW IV DRUG ABUSE MANDATE, THE INCREASE OF THE WOMEN'S SET-ASIDE FROM 5 TO 10 PERCENT, AND THE CREATION OF A REVOLVING FUND FOR GROUP HOMES REQUIRED STATES TO REVAMP STATE PRIORITIES TO RESPOND TO THESE FEDERAL MANDATES.

FACTORS RELATED TO STATE DRAW DOWN OF ADMS BLOCK GRANT

SEVERAL FACTORS CONTRIBUTE TO THE MANNER IN WHICH STATES USE ADMS BLOCK GRANT MONIES. FIRST OF ALL, THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT FUNDS ARE AVAILABLE TO STATES ON A "DRAW DOWN" BASIS THAT PERMITS FUNDS TO BE TAKEN FROM THE FEDERAL TREASURY A MAXIMUM OF ONLY TWO OR THREE DAYS BEFORE A STATE WRITES CHECKS TO REIMBURSE COMMUNITY PROGRAMS FOR SERVICES; ONLY AT THIS TIME DOES THE COMMUNITY PROGRAM EXPENDITURE SHOW AS A DRAW DOWN, I.E. "SPENT" BY THE STATE. IN FACT, THE FUNDS HAVE BEEN ACTUALLY SPENT BY COMMUNITY AGENCIES AS LONG AS SEVERAL (THREE TO FOUR) MONTHS BEFORE THE FEDERAL MONEY IS DRAWN DOWN AND HAVE BEEN LEGALLY OBLIGATED BY THE STATE TO COMMUNITY PROGRAMS AS LONG AS 12 MONTHS PRIOR TO THE DRAW DOWN. THUS, FOR STATES, THE ADMS BLOCK GRANT OPERATES PRIMARILY AS A REIMBURSEMENT MECHANISM.

AS PROVIDED FOR ON THE 1988 DRUG BILL, THE BLOCK GRANT AWARD NOTICE SENT BY THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA) TO THE STATES INDICATED THAT THE MONIES WERE AVAILABLE FOR OBLIGATION UNTIL SEPTEMBER 30, 1989 AND FOR EXPENDITURE (DRAW DOWN) UNTIL SEPTEMBER 30, 1990. IT IS UNREALISTIC TO EXPECT STATES TO HAVE DRAWN DOWN THE MAJORITY OF FY 1989 FUNDS AT THIS POINT IN TIME, ONLY SEVEN MONTHS INTO A 24 MONTH EXPENDITURE PERIOD.

ALL STATES IMPLEMENT A CAREFUL AND DELIBERATE PLANNING PROCESS IN ORDER TO ENSURE THAT MONIES ARE UTILIZED IN A COST EFFECTIVE MANNER WHERE THEY ARE MOST NEEDED - IN MANY STATES THIS PROCESS INVOLVES THE STATE LEGISLATURE'S REVIEW AND APPROVAL OF THE ALLOCATION OF THESE IMPORTANT RESOURCES. ALSO, IN A FEW STATES THE LEGISLATURE MEETS ONLY ONCE EVERY TWO YEARS. AFTER STATES GET THE NECESSARY AUTHORITY AND FINAL APPROPRIATIONS LEVELS, MOST STATES USE A FAIR AND EQUITABLE COMPETITIVE PROCUREMENT PROCESS TO SELECT COMMUNITY BASED TREATMENT PROVIDERS.

CONCLUSION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, BE ASSURED THAT THE STATES AND LOCAL COMMUNITIES ARE INDEED USING THE ADMS BLOCK GRANT MONIES AS WISELY AND EXPEDITIOUSLY AS POSSIBLE. WE LOOK FORWARD TO A CONTINUED AND STRENGTHENED PARTNERSHIP WITH THE CONGRESS AND THE ADMINISTRATION TO TARGET MORE FEDERAL RESOURCES TO ALCOHOL AND OTHER DRUG ABUSE TREATMENT AND PREVENTION SERVICES NATIONWIDE.

ATTACHMENT I OF OUR STATEMENT PROVIDES DETAILED JUSTIFICATIONS FOR OUR REQUEST FOR INCREASED APPROPRIATIONS FOR FISCAL YEAR 1990 FOR THE ADMS BLOCK GRANT AS WELL AS FOR THE ACTIVITIES OF THE OFFICE FOR SUBSTANCE ABUSE PREVENTION, THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM AND THE NATIONAL INSTITUTE ON DRUG ABUSE. THESE RECOMMENDED FUNDING LEVELS REFLECT A CONSENSUS OF THE ALCOHOL AND DRUG ABUSE FIELD.

Mr. GUSTAFSON. Thank you, sir.

Senator ADAMS. Thank you very much, Mr. Gustafson.

I wanted you also to know that 10 days ago I was in the center in Seattle. I think the block grants are being well used. I think we are inadequate in that we are not able to give immediate treatment in some cases, but it is certainly being overwhelmed by both our homeless problem and the beginnings of the crack problem. And so, I appreciate your testimony very much, and I am very supportive of it.

Mr. GUSTAFSON. Thank you very much. We look forward to putting in place the $75 million to purchase the so-called waiting list that we are now submitting applications for across the country, and that will be an excellent start of admitting those people who are currently unable to access treatment into helping services that they need.

Senator ADAMS. Well, I determined—and I do this all the time in terms of visiting, but in my last visit that in particular with the new substances—and I mention crack only because it happens to be one that is being discussed a lot, but there are several other chemical substances—that if there is not an acceptance for treatment within a 2- to 3-day period, in fact, even less than that, you get an immediate cycling back out onto street. It is not like the alcohol and heroin problem where you maybe have a little more time. So, a waiting list there simply means a rotation and that you simply don't reach the people at all.

Mr. GUSTAFSON. That is very true, Senator. I have a quick chart that I would like to leave with you which shows the dramatic increase in cocaine as a primary drug abuse and people presenting for treatment over the last 3 years. It has gone up from 39,000 up to 139,666 in 4 years alone.

Senator **Adams**. Thank you. Without objection, that will be included in the record at this point.

[The information follows:]

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY '90	Our Proposal FY '90
ADMS Block Grant	$805.6	$800.0	$834.6	$1600.0

The Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant is the foundation of funding for alcohol, other drug abuse and community mental health services, helping to forge a partnership among federal, state and community providers. The ADMS Block Grant, established in 1981 to finance community servies, was expanded and restructured as part of the Omnibus Anti-Drug Act of 1988 (P.L. 100-690). The new ADMS Block Grant consists of the previous program (alcohol, other drug abuse and mental health services), the Emergency Alcohol and Drug Treatment Block Grant, and a new emphasis on increasing treatment to intravenous drug users to reduce the transmission of AIDS.

In FY 1989, $805.6 million (which includes the $125 million provided by P.L. 100-690) was made available for these purposes: $518.3 million for alcohol and other drug abuse prevention and treatment servies, $247 million for community mental health services and $40.3 million for data collection, evaluation and technical assistance. For FY 1989, States were required to expend 50 percent of their share of the $125 million for substance abuse treatment services to intravenous drug users. From the alcohol and drug portion of the block grant 20 percent is mandated for prevention activities and 35 percent for alcoholism and alcohol abuse services. Ten percent of the entire ADMS Block Grant was to be spent on alcohol and other drug abuse services for women.

P.L. 100-690 altered the allotment formula used to distribute funds to the States for alcohol, drug abuse and mental health programs based on population in need, emphasizing urban populations and total taxable resources, a new measure of State's fiscal capacity. This new formula dramatically shifts funds among States and causes several States to actually receive less money than in FY 1988. A "hold harmless" provision with a four year phase-out, allows certain portions of the Block Grant to be distributed on the basis of the original 1981 formula.

P.L. 100-690 also requires the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) to set aside a minimum of 5 percent of the entire block grant (allowing up to 15 percent of the total) for national data collection, services evaluation and technical assistance. In FY 1989, ADAMHA took its statutory minimum of 5 percent ($40.3 million). However, ADAMHA has stated its desire to take "approximately 7 percent" in FY 1990 which will further reduce the total monies available for alcohol and other drug treatment services.

For FY 1990, President Reagan had proposed funding the Block Grant at $800 million, a $5 million decrease. In his budget message, President Bush proposed a 12 percent increase for federal drug abuse spending, though amounts were not specified for the Block Grant. However, the budget apparently places the ADMS Block Grant within the "flexible freeze" and a cut as high as 10 to 15 percent below the current services budget (adjusted for inflation) could occur.

Because of the uncertainty regarding President Bush's proposed funding levels for the Block Grant, it is particularly important that Congress increase the amounts designated for the ADMS Block Grant to allow the nation to respond to the crisis of the large and growing number of underserved people with alcohol and other drug problems and with serious mental illness who are homeless, in rural areas, elderly, children and minorities. Additionally, a flexible freeze would not permit the nation to meet the demand for alcohol and other drug servies by the general public, DWI and drug dependent offenders, cocaine and crack addicts, and intravenous drug users who are at high risk of contracting and spreading AIDS.

The Coalition recommends that the Alcohol, Drug Abuse and Mental Health Block Grant be funded at $1.6 billion for FY 1990 to provide for an increased capacity to address the need for alcohol and other drug prevention and treatment. In order to assure the States' ability to effectively plan for and manage Federal funds, appropriations levels should: 1) reflect a long term commitment by the Federal government to provide a stable funding base for the development of comprehensive programs based on the specific and unique needs of each State; 2) ensure that monies to all State are increased and that no State suffer reductions or cuts in monies or existing services, specifically including continuation of servies established for the reduction of waiting lists; and 3) reflect the intent of Congress and the Administration by fully funding the recently enacted Anti-Drug Bill (P.L. 100-690).

Office for Substance Abuse Prevention
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY '90	Our Proposal FY '90
Demonstration Projects	56.1	57.1	60.6	114.3
Training	5.0	5.3	5.4	27.3
Program Management/ Support	8.7	9.8	10.9	12.7
Total	69.8	72.2	76.9	154.3

The Office for Substance Abuse Prevention (OSAP) was created by the Anti-Drug Abuse Act of 1986 to consolidate Department prevention efforts relating to alcohol and other drugs of abuse as well as to develop new prevention initiatives with particular emphasis on high risk youth. Established as a separate office within the office of the Administrator, OSAP responsibilities included the operation of the National Clearinghouse for Alcohol and Drug Information and its related activities, community technical assistance contracts, and a grant program for high risk youth. The grant program, the largest component of the OSAP budget, accounted for more than two-thirds of the total OSAP budget in FY 1988.

The Anti-Drug Act of 1988 significantly expanded the scope and functions of OSAP, establishing it as a fourth separate entity within ADAMHA, increasing its responsibilities to include four new programs, and broadening its mandate toward a more community-wide focus. OSAP now is responsible for developing and implementing: a model demonstration program for drug addicted pregnant women, pospartum women and their infants; a state-coordinated community youth activity program; a national training system for substance abuse prevention and treatment; and a community-wide grant program to develop long term strategies for the prevention of substance abuse. In 1989, OSAP initiated these new programs while continuing to nurture and develop the high risk youth grants, clearinghouse and other on-going activities. The aim is to establish a productive comprehensive program that will address the alcohol and other drug abuse prevention needs of the Nation.

Demonstration Project:

Of the amount appropriated for OSAP in FY 1989, 56.1 million was mandated for demonstration projects. Approximately sixty percent of the monies are being used to continue programs generated under the Anti-Drug Abuse Act of 1988 for high risk youth. Only modest numbers of the new programs will be developed. For example, 25 new programs will be funded for pregnant addicted women and/or postpartum women and infants. The birth of addicted babies to women with drug problems is a serious national problem. We urge the appropriation of 5.5 million in new monies to expand these efforts.

In responding to requests from all over the country for assistance in developing or strengthening prevention services; OSAP has become increasingly aware of the necessity of initiating a comprehensive multi-disciplinary approach, particularly in working with larger communities. In recognition of the fact that substance abuse prevention is a long range, comprehensive process, the Administration requested 35 million to initiate community partnership grants for drug abuse prevention. This proposed intiative would demonstrate the effectiveness of community coalitions of organizations representing youth, parents, health professionals, clergy, schools, businesses, and local officials in planning and implementing comprehensive prevention programs. The communities would develop their own programs and design them to become self-sustaining; not dependent on permanent Federal support. Emphasis would be placed on substantial voluntary participation in the community. Local businesses would be encouraged to participate and include opportunities to provide jobs and career development programs to drug-free youth. Strategies funded would ensure the provision of appropriate support services including peer group services, family counseling, juvenile justice activities, employment assistance and interaction with the school system. We support the recommendation of the Administration and urge the appropriation of $35 million to fund this new initiative.

Training:

OSAP has the legislative mandate to provide leadership in support of community program development. There is a great need to develop a national training system. This system would be responsible for increasing and expanding current professional resources. National needs assessment, training curricula, organizational development, replication of program models, social policy action, and continuing education opportunities would be the major components of this system.

OSAP conducted a prevention training needs assessment during the summer of 1988. One of the recommendations from that assessment was for funding for each state to support a prevention training capacity to provide continuing training and technical assistance to community agencies, professionals, and volunteers. The Coalition supports this approach and urge an appropriation of 18 million to support state training activities.

The national system would coordinate all National prevention efforts. A major activity would involve training and program development in specific problem areas such as teen pregnancy and cocaine babies. It would play a role for access, contact and coordination with other Federal agencies and initiate cooperative prevention activities. Included in this package will be an on-going evaluation of the activities of this office. We support and urge the appropriation of 27.3 million to support this initiative.

Program Management and Support:

The Coalition recognizes that to effectively manage these expanded programs, provide technical assistance, and operate the Alcohol and Drug Abuse Clearinghouse (which received over 12,000 requests for information/month) and design the new grant evaluation projects, there is a need for more federal personnel. We recommend an increase of 50 FTEs to support these activities.

NATIONAL INSTITUTE FOR DRUG ABUSE
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

AIDS
(dollars in millions)

	Estimate FY '89	President FY '89	Current Services FY '89	Our Proposal FY '90
NIDA	120.5	139.9	139.9	151.4
NIAAA	8.1	8.3	8.3	8.9

NIDA and NIAAA must play a major role in the Government's war against the AIDS epidemic because of the growing numbers of IV drug users who contract AIDS and transmit the virus to sexual partners and children. The Nation has now recognized that the battle against the spread of AIDS will be fought primarily on the drug abuse front.

The Institutes are the experts in drug and alcohol research, prevention and treatment and must be given the necessary funds to continue this vital work if we hop to stem the spread of HIV. This proposal will enable the Institutes to research effective prevention strategies, design innovatie outreach programs to drug users and demonstrate model treatment services for IVDU's and other addicted individuals. These funds are an important supplement to the drug and alcohol treatment funds provided to states under the ADMS block grant.

Of the approximately $151 million requested for NIDA, we propose that approximately $52 million be used for extramural and intramural research. Specific research programs, many of which were recommended by the National Research Council, that should be supported include:

- o Research into improved drug-use treatment, including studies of pharmacotherapy and other treatment modalities for cocaine dependence.
- o Research into improved recruitment strategies to attract more persons to treatment and retention strategies to keep people in treatment, making it more effective.
- o Research into strategies to prevent and deal most effectively with relapse.
- o Research and development of data collection systems for monitoring current AIDS prevention efforts for IVDU's.
- o Research about IVDU's who are not in contact with health care, drug-use treatment or criminal justice systems.
- o Research into AIDS prevention strategies among adolescents, IVDU's and their sexual and needle-sharing partners.

We also propose that approximately $94 million be used to fund new and existing demonstration projects. We believe the President's recommended $10 million reduction for outreach demonstration projects is ill-advised at a time when the disease is spreading among IVDU's and their contacts and no definitive model has been found for preventing HIV transmission in this population or attracting drug users into treatment. Risk-reduction and prevention messages must be taken to drug users on the streets, consistent with the National Research Council recommendation to expand existing "programs that provide for 'safer injection' to reach all current IV drug users in evaluation."

treatment demonstration projects should also be expanded to ensure that the most effective treatment approaches are offered to drug users. In addition, the National Research Council's call for "randomized field experiments for evaluating new intervention programs on both individual and community levels" should be supported.

Research has demonstrated that acute and chronic alcoholism can suppress immune function. Alcohol consumption may, therefore, be an important co-factor in the development of AIDS and opportunistic infections. In addition, as with any drug, there is concern that alcohol consumption may elicit behaviors that increase the risk of HIV infection.

The NIAAA has undertaken important research into the effects of alcohol use on the development of the disease. Its research efforts should be continued and expanded. We, therefore, propose that approximately $8 million of the $8.9 million request be used for extramural and intramural research.

Specific research programs that should be supported include:

- Research on the effects of alcohol on the biological mechanisms underlying the risk for acquisition of HIV infection and progression from HIV infection to development of opportunistic infections and clinical AIDS.
- Epidemiologic research on the extent of alcohol use and alcoholism among AIDS patients, HIV infected individuals and populations at risk for infection.
- Research on the link between alcohol use and risk-taking behaviors related to unsafe sex practices and drug use and the development of strategies to reduce alcohol-related risk-taking behaviors.

The NIAAA also provides important prevention services by disseminating research information concerning AIDS and alcoholism to treatment providers and other health professionals. We have proposed that approximately $380,000 be used to expand such services. By training alcohol treatment personnel in the latest research, they will be able to serve patients who have AIDS or are at risk for HIV infection and provide prevention education to all clients.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA) RESEARCH
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY '90	Our Proposal FY '90
Research Extramural & Intramural	$102.8	$109.4	$121.2	$138.7
Demonstrations Homeless	4.5	0*	4.8	17.0*
Res. Mgmt. & Support	9.2	10.3	10.3	11.6
TOTAL	$116.5	119.7	136.3	167.3

The NIAAA is the lead federal agency responsible for reducing the health, social and economic consequences of alcohol abuse and alcoholism in the United States. An extimated 10% of adult Americans are sufferers of serious alcohol-related problems. Committed to the development of a strong knowledge base, the Institute supports a comprehensive program of extramural and intramural research aimed at developing effective treatment and prevention strategies.

The FY 1990 budget request is far short of what is needed to accomplish these research goals. Specificallly, the FY 1990 request will support an estimated 451 research grants, compared to 468 in FY 1989. Of the 451, only 88 new and competing project grants would be funded, which is 66 fewer than in FY 1989.

The purpose of the NIAAA reserch program is to improve the treatment and prevention of alcoholism and alcohol-related problems. Through research we have learned that alcohol abuse is a widespread problem arising from a complex interplay of biological, psychological and environmental factors. Recent advances in the alcohol research field are showing evidence that susceptibility to alcohol problems is inherited in many cases. Researchers have found genetic differences in alcohol metabolizing enzymes that could help to explain individual differences in vulnerability to alcoholism.

In addition, progress has been made in the area of behavioral determinants of alcoholism. Even among those who are genetically predisposed to alcoholism, other psychological and environmental factors contribute to this complex disorder. Research has shown the significance of environmental situations relative to alcohol addiction and craving, and relapse after withdrawal. Other studies have revealed that tolerance to alcohol may be impacted through behavioral conditioning techniques.

Treatment research, historically a priority at the Institute, is receiving heightened focus and has been identified as an area to be expanded. Many questions remain about the relative efficacy of different therapies for different types of patients.

Among the myriad of questions concerning treatment is how to place patients so that they will receive the most effective rehabilitation and treatment available. Also, because the diagnostic criteria for assessing alcoholism have changed significantly in recent years, there is the need for more research to improve methods for determining an accurate diagnosis of the type of alcoholism. The more accurate the diagnosis, the greater the chance for successful treatment. Two years ago, the criteria was revised to include a broaded number of indicators. In the past alcohol addiction was defined in terms of evidence of tolerance or withdrawal symptoms. The revised criteria include behavioral indicators as well. Yet, little is known about the validity, reliability and clinical utility of these criteria.

Another major priority in the area of treatment relates to effective treatment modalities. In particular, the NIAAA is looking at new pharmacological agents to reduce the desire for alcohol, which may prove to be more effective than the traditional pharmacological treatment using Antabuse.

Prevention research is critical addressing the problems of alcoholism and alcohol abuse. The NIAAA is working on developing practical measures to prevent and reduce alcohol-related problems. Progress is being made in increasing our understanding about prevention, yet many questions remain unanswered. For example, there is a critical need for improved methods for evaluating prevention approaches. In addition, the Institute is placing special emphasis on research on economic and socioeconomic issues in the prevention of alcohol abuse. In fact, the NIAAA recently published a program announcement in this area urging scientists to submit applications for research on this topic.

Other prevention research topics include alcohol advertising and its contribution to a pro-drug environment. This area requires much further assessment. Research related to driving deterrance must also continue. The impact of changes in the law provides numerous opportunities for evaluation relative to effectiveness and efficiency.

In FY 1989 under the Stewart B. McKinney Homeless Assistance Amendments of 1988, $4.5 million was earmarked for the homeless demonstration program at the NIAAA. Specific research and treatment efforts need to focus on homeless individuals with alcohol and drug problems. The NIAAA Homeless Demonstration Project is providing this needed focus and will enhance national efforts to serve this traditionally underserved population. The program initiated with funding made available in 1987 has supported nine demonstration grants and one evaluation project. Although the FY 1989 budget included a third year of funding and the Reagan budget recommended zero funding in FY 1990, President Bush made revisions to the Reagan budget, requesting full funding for all McKinney Act programs. With this recommendation $17 million would be made available for a homeless demonstration project in FY 1990 to be administered by NIAAA in collaboration with NIDA. We support this recommendation as a measure to provide continued assistance to homeless individuals and families who are suffering from the consequences of alcohol and drug abuse.

With so many new leads to explore about the causes, effectiveness and prevention of alcholism and alcohol problems, it is critical that adequate resources be allocated to sustain existing programs and support new investigations sponsored by the NIAAA.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) RESEARCH
(dollars in millions)

	Estimate FY 89	President FY 90	Current Services FY 90	Our Proposal FY 90
Research Extramural & Intramural	$146.3	$154.9	$160.2	$172.3
Demonstrations	7.0	7.0	7.4	10.0
Res. Mgmt. & Support	15.0	16.4	16.4	18.4
TOTAL	168.3	178.3	184.0	200.7

The National Institute on Drug Abuse (NIDA) provides leadership for a national program of research on drug abuse. Supporting basic research, clinical and epidemiologic studies, demonstration and education projects, the NIDA addresses pressing questions about the causes, consequences, incidence and prevalence, prevention and treatment of drug abuse through its intramural and extramural research programs.

The incidence of illicit drug use and the number of new drugs being used are unprecedented. Faced with what is clearly a drug epidemic, the need for research has never been greater. Responding to this alarming situation, the NIDA has identified several research priorities requiring added attention and maximum resources which include: the development of new treatment approaches pharmacologic agents; prevention strategies; vulnerability to addiction; and treatment evaluation.

In the last three years, the Institute has supported significant research to improve our ability to treat dependent persons. Progress has been made in treating heroin abusers with the development of pharmaceuticals which inhibit the desire to use heroin. However, special emphasis must be given to the development of new pharmacologic agents to aid in the treatment of cocaine, cocaine derivatives, and PCP.

Prevention efforts are also targeted for expansion at the NIDA. There remain major gaps in our knowledge base about effective prevention strategies. We know very little about how to prevent occasional drug abusers from progressing to chronic use. Moreover, we are not able to distinguish those individuals who will respond to peer pressure resistance programs from those who will not.

Prevention research involves an array of scientific disciplines which seek to identify biologic, behavioral and social indicators, and precursors to drug abuse. The development of interventions is also important as a tool for testing the efficacy of theory-based prevention strategies. To assess prevention programs, the NIDA sponsors evaluations to determine the degree to which drug education: 1) increases the perception of harm resulting from drug abuse; 2) increases the perception of social disapproval of drug abuse;

3) promotes anti-drug attitudes; and 4) teaches appropriate behavioral skills to resist social pressure to use drugs.

The NIDA has begun to demontrate that drug prevention can result in meaningful changes in drug-related behavior and actual drug use. New directions in prevention research point to environmental and developmental studies; research on multiple problem behaviors; and learning research.

Addiction research is also high on the Institute's agenda. With a better understanding of why certain individuals are more vulnerable to drug dependence than others, researchers will be able to identify those at-risk and develop population-specific prevention and intervention programs.

The NIDA has enhanced treatment outcome research activities, recognizing the need for evaluation of treatment programs currently and soon-to-be in the mainstream. There are plans for more research on environmental factors in treatment looking at the psychological and organizational climate, patient needs, matching patients to treatment modalities, and problems in enlisting and retaining patients in drug treatment programs.

The FY 1990 does not provide sufficient funding to effectively support an expansion in these and other research areas. Under the Administration's budget request, the NIDA would only be able to support 167 new and competing research project grants, 33 fewer than in FY 1989. Including continuations, only 488 project grants could be awarded in FY 1990 under the President's request, compared with 524 funded in FY 1989.

With the recent congressional mandate to enhance our knowledge base and improve our understanding of the causes of drug abuse and to develop effective treatment and prevention methods, it is imperative that the federal government makes a substantial investment in research and related activities.

RESEARCH TRAINING
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY '90	Our Proposal FY '90
NIDA	$2.4	$2.4	$3.0	$6.6*
NIAAA	2.6	2.7	3.4	5.5

The success of behavioral and biomedical research on addictive disorders depends on a continual infusion of new ideas from innovative scientists. The NIDA and NIAAA research training programs strengthen the research effort by encouraging young scientists to pursue research careers in the alcohol and drug abuse fields, by selecting through peer review the best qualified candidates, and by fostering strong training environments.

Since the early years of the Reagan Administration, funding support for research training at these institutes has steadily declined. Not surprisingly, between FY 87 - FY 89, the number of trainees supported by the NIDA and NIAAA dropped significantly.

The NIAAA supports training in the biomedical and behavioral sciences helping young investigators develop the expertise required for basic alcohol research in genetics, molecular biology, behavioral sciences, and the neurosciences, and for applied research in the treatment and prevention of alcohol abuse. The FY 1990 budget request will support 103 institutional and individual awards at the NIAAA, eight less than in FY 1989.

The NIDA research training program is also intended to support young scientists, providing them with the most current training in the behavioral and biomedical sciences. The President's budget request will support 13 fewer NIDA training grants in FY 1990 and no new awards will be funded.

In 1985, the Institute of Medicine (IOM) recommended that research training funding be increased substantially to avoid a shortfall of behavioral and biomedical research scientists. Further, the IOM pointed out that the training of researchers is essential to fulfill the needs of evolving areas of specialization. An increased investment in this area is particularly important as the nation anticipates higher rates of attrition among senior scientists due to death and retirement and the long lead time needed to develop skilled researchers. Moreover, we can also expect that inflation, rising tuition and other educational costs will have an impact on research training.

To remedy the dramatic decline in the Institutes' capacity to support young researchers, we believe that extraordinary measures must be taken to help restore the nation's research capacity in the alcohol and drug abuse fields. We recommend a signficant increase in research training funds to support 228 research trainees at the NIDA and 209 research trainees at the NIAAA. This additional support will permit both Institutes to initiate training in current areas that are significantly neglected and to train investigators for developing evaluative, analytic and interpretive techniques focused on the primary prevention of substance abuse.

* $.6 million of the recommended $6.6 million is for NIDA AIDS research training.

Senator Adams. So that all of the rest of you understand, I am not just focusing on this particular problem. It is just that we had 52 homicides in Washington, DC, in the month of January, and we have had 300 in the first 3 months. This is related to mental health, substance abuse. It is escalating throughout the entire country. We have to attack this from a research and treatment viewpoint even though all of us are talking right now, our main problem is trying to get the people off the streets just simply to stop the killing.

That's why I addressed the particular question to you and to all of the witnesses so that you are thinking about this. If we can't keep these people off the street, they immediately cycle back and our chances of violence in some cases double or even triple.

Thank you very much for your testimony. We appreciate it.

Now, I have just been informed by staff that two witnesses have to catch early flights out. It would help if I could take two witnesses out of order. I don't want anybody to have to wait, but I will try to accommodate everyone I can.

STATEMENT OF JOHN A. DOYLE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Senator Adams. John Doyle of the National Association of Rehabilitation Facilities. Mr. Doyle, I understand that you have an early flight, and we would be happy to accommodate you.

Mr. Doyle. Thank you, sir, and members of the committee and staff. Thank you for accommodating that request. And to the other witnesses, thank you too. If I am invited back next year, Mr. Chairman—and I will try to do some things to encourage that like being brief—I will be happy to stand at the end of the list.

Senator Adams. I will be pleased to hear your testimony.

Mr. Doyle. Mr. Chairman, I ask that my testimony as it has been submitted be accepted for the record as if read.

Senator Adams. Without objection, it is so ordered.

Mr. **Doyle**. Mr. Chairman, summarizing the testimony this morning, I would really like to just focus on one point. Included in the testimony is a discussion of several areas of concern to persons with disabilities and to providers who provide the necessary services to them promised under law. The key word there is promise.

All too frequently we as advocates, the Congress particularly in its authorizing roles and the administration's successive appointments tend to focus on new initiatives because those are what are bright, cheery, they create new promises. The problem is we never go back and fulfill the old ones.

In the several programs that I have mentioned in my testimony, I ask that this committee focus on the difficult, maybe less spectacular and less sexy, but nonetheless most necessary job of fulfilling that promise to persons with disabilities that they have the opportunity for job training, that they have the opportunity for medical and vocational rehabilitation services, and that the programs designed with care and proven over time, like the projects with industry program, the vocational rehabilitation training program, have the opportunity to fulfill their full promise made oftentimes many, many years ago.

Just one anecdote, Mr. Chairman. With the explosion of the aging population, the need for medical rehabilitation services, manpower is a very critical need. In many cases there just aren't sufficient numbers of physical therapists, occupational therapists, or speech therapists. Congress passed a law last year authorizing some $6 million in terms of faculty improvement and/or training grants. To date none of that money, I don't believe, has been appropriated.

In a school in my home State of Connecticut, the full class of physical therapists—every one of them—went on to private practice. Not a one was available for State institutions. Not a one was available for private hospitals or medical rehabilitation facilities. This kind of paucity increase skyrockets cost of rehabilitative care, skyrockets the cost of care for the elderly, care for the disabled. Mr. Chairman, I think we can make a start at it if you and this fine committee can begin to fulfill promise of some of the bills I've mentioned.

Thank you very much, Mr. Chairman.

PREPARED STATEMENT

Senator **Adams**. Thank you very much, Mr. Doyle. Your statement will appear in full, and we appreciate very much your testimony this morning.

[The statement follows:]

STATEMENT OF JOHN A. DOYLE

I would like to thank Chairman Harkin, and the other members of the Subcommittee for allowing me to present testimony on behalf of the National Association of Rehabilitation Facilities. NARF is a national association representing over 700 community-based vocational, medical, and residential rehabilitation facilities. NARF membership is composed of a mix of rehabilitation provider organizations, including developmental centers, sheltered workshops, supported employment programs, projects with industry, freestanding rehabilitation hospitals, acute care hospitals with rehabilitation units, comprehensive outpatient rehabilitation facilities, residential and long-term care providers, as well as numerous other programs aimed at helping people with disabilities.

Our statement addresses the Rehabilitation Act, the Health Omnibus Programs and Extension Act of 1988, Title XX, and the Job Training Partnership Act.

The Rehabilitation Act of 1973 remains the foundation for vocational services for persons with disabilities. The Administration has asked that the Vocational Rehabilitation State Grant Program be increased by $52 million dollars for FY 1990 to $1.502 billion. These dollars will just allow us to keep up with inflation. Presently, an estimated 925,000 persons with disabilities are served, or approximately 1 out of every 20 eligible individuals.

NARF recommends that the Subcommittee fund the State Grants Program at the level authorized, $1.705 billion. Additional funding for this program will allow states to maintain the level of services presently being provided, while assisting many more thousands of individuals.

Also part of the Rehabilitation Act is the Supported Employment Program. Supported Employment offers persons with disabilities the opportunity to participate in competitive work in integrated, community-based settings. In addition, the program provides ongoing support for individuals with disabilities to assist them in performing their jobs. NARF recommends that the full authorization level of

$29.73 million be appropriated. This would be an increase of less than $3 million over last year's appropriation.

Another program authorized under the Rehabilitation Act, and of great importance to individuals with disabilities, rehabilitation facilities, community organizations, labor unions, and businesses, is the Projects With Industry (PWI) program. This program fosters public/private partnerships through Business Advisory Councils. The training is designed specifically for jobs available in the business community. Presently, 115 PWI projects are being funded at the FY 1989 appropriations level of $17.35 million. Additional dollars should be appropriated for this program to allow existing projects to increase the present level of services and to allow many more sites to be funded, as well as reflect an increase in inflation. We suggest an increase to the full authorization level of $19.149 million.

Rehabilitation facilities, both medical and vocational, continue to face severe shortages in personnel and training programs that provide in-service and retraining for existing staff. There are two primary sources for needed training funds: the Health Omnibus Programs and Extension Act of 1988 and the Training Authority (Title III, Section 304) under the Rehabilitation Act.

Title VII of the Public Health Service Act historically had provided funds for education of health professionals, including allied health professionals such as occupational therapists, physical therapists, speech-language pathologists and audiologists. There has not been any funding for allied health, however, since 1980.

The 100th Congress enacted the "Health Omnibus Programs and Extension Act of 1988", P.L. 100-607, which contains two provisions that would make available in each of FYs 90 and 91, $2 million for faculty and program strengthening and for traineeships for advanced training of allied health professionals, including rehabilitation therapists. However, these funding levels are grossly inadequate to meet the present rehabilitation needs of the nation's elderly and persons with disabilities.

Given the extreme shortages of occupational and physical therapists, speech-language pathologists, and audiologists, NARF recommends that the Subcommittee appropriate the full authorization level under P.L. 100-607 of $4 million total for FY 1990.

Training for personnel for vocational rehabilitation facilities is funded through Section 304 of the Rehabilitation Act of 1973. Training for rehabilitation personnel has not fared as well as some other rehabilitation programs. For several years, the Administration tried to gut the program even though there was a demonstrated need for professionals in the field. Appropriations for rehabilitation training was $31 million in 1979. It fell to $19 million in 1982. Last year, it was funded at $30.5 million, still less than the FY 1979 appropriation. NARF requests that the Subcommittee appropriate the authorized level of $37 million for FY 1990.

The Title XX Social Services Block Grant is a major source of funding for non-institutional community-based services that serve individuals with disabilities. In many states, this program provides the funding that allows individuals to remain self-supporting. Title XX has remained funded at the $2.7 billion level for many years now. While the program has stayed at this funding level, inflation has eroded the degree of service that this program provides. NARF recommends that Title XX be funded at the $3.3 billion level, even though the authorization level is $2.7 billion. Congress has given considerable consideration to increasing funds for Title XX, we feel that the need for those dollars cannot be delayed any longer.

The Job Training Partnership Act (JTPA) provides job training services to disabled individuals through the State Grants Program (Title IIA), and through seven national projects financed by the Pilots and Demonstrations Account (Title IV).

We are very interested in seeing an increase in Title II-A funding because of the excellent services that have been provided through this title of the program in the past. But increased Title II-A dollars are also particularly significant since the passage of the Stuart B. McKinney Homeless Assistance Amendments Act of 1988, which contained a provision called "Jobs for Employable Dependent Individuals Bonus Program," or JEDI. The JEDI program will pay states a bonus when they utilize JTPA funded services to place welfare recipients and disabled SSI beneficiaries into jobs. This provides a tremendous incentive for states and service providers. Unfortunately, this innovative initiative cannot be supported unless funding for the basic grants to states under Title II-A is increased beyond the JTPA cost-of-living increase for this year.

The seven projects under Title IV operate nationwide in 65 sites, and placed 9,000 individuals into jobs in FY 1986. Last year, appropriations levels for both of these programs under JTPA were significantly cut.

NARF recommends that funding for the block grant (Title IIA) and the Pilots and Demonstrations Program be returned to at least the 1988 appropriations level of $1.809 billion and $39 million, respectively.

Mr. Chairman, on behalf of the National Association of Rehabilitation Facilities, I thank you again for this opportunity to share our views on these important issues.

Senator ADAMS. Staff has asked that I have one question here presented to you.

Mr. Doyle, I understand that you presently serve on the board of Job Accommodation Network of America, Inc., which is an organization founded to secure private funding to supplement the Department of Education funds for the Job Accommodation Network [JAN] of West Virginia University. Would you please provide the subcommittee with a summary of JAN's activities to date, demands for its services, and the estimated cost of operation for fiscal year 1990? I would also appreciate any information you may have on JAN's use by Federal or State government agencies.

Mr. DOYLE. Thank you, Mr. Chairman. If I might, I would like to submit a complete answer to that question for the record before the May 15 date.

Suffice it to say that West Virginia University's JAN program is a critical need to persons with disabilities. Most simply what it does is it assists an employer. If you want to hire a person with a disability, you have a place to call to see what kind of job site modifications can be made and what kind of other assistance you can provide to make that person with a disability a viable, productive worker.

West Virginia University has been administering this program. In the last year alone, the number of increased calls for assistance was up almost 43 percent.

The Canadian Government itself has recognized JAN's good work, and it has contracted with West Virginia University to provide similar services in that country.

I serve as a voluntary board member on the JAN board. I am pleased and proud to be associated with the effort. I will submit a complete answer for the record, but it is a most worthwhile program that really gets to the nub of getting persons with disabilities to work because it is the employers themselves who actually make these calls.

Senator ADAMS. Excellent. Thank you very much. We appreciate your testimony.

STATEMENT OF TIMOTHY J. GOGGINS, DIRECTOR OF DEVELOPMENT, NATIONAL HEAD INJURY FOUNDATION, INC.

Senator ADAMS. The next witness that we would like to accommodate, if we could, at this time is Timothy Goggins, National Head Injury Foundation. Mr. Goggins.

Mr. GOGGINS. Thank you, Mr. Chairman. I appreciate your accommodating me.

Senator ADAMS. We understand that, and we will try to do that.

Mr. GOGGINS. I would like to have my remarks submitted for the record in their entirety.

Senator ADAMS. Without objection, the entire statement will appear as read in the record.

Mr. GOGGINS. I will summarize. My name is Tim Goggins. I am the director of development of the National Head Injury Foundation, and I am pleased to testify before you today on behalf of Marilyn Price Spivack, our president, and the foundation.

I want to thank the committee for their support of the foundation's efforts over the years, particularly their support of the recent initiative with the interagency task force on head injury. I understand at the present time that the report from that task force is pending before Dr. Sullivan in his office and it is yet to be released. We would appreciate the support of the committee in getting that report released on time in accordance with the publication schedule.

Last week the National Institute on Disability Rehabilitation Research released their proceedings of a 1987 conference on head injury which we feel will be most helpful to the National Head Injury Foundation in our efforts on behalf of our constituency, and we also feel it would be a great service along with the task force in aiding this committee in their work.

Today, I am here, as we have been since 1982, to testify on behalf of traumatic brain injured individuals particularly for access to health care on their behalf and to a quality continuum of health care over a period of time to rehabilitate them to be productive citizens. This we feel was the intent of Congress when they passed the Developmental Disabilities Act which stated that they were to provide the services to enable persons to achieve their maximum potential through increased independence, productivity, and integration into the community.

Sadly, today, on a national basis, long-term care for individuals with traumatic brain injury is sporadic to nonexistent. This problem is based in part on access, in part on eligibility, to some extent on discriminatory practices that we believe are a result of title XIX of the Social Security Administration which target and focus on a testing for mental retardation as the eligibility criteria.

Compounding this problem we feel is a lack of awareness which exists even in the medical community today, physicians, psychiatrists, and psychologists, who are yet unable to really fully appreciate the value of long-term rehabilitative care.

At a recent international head injury conference, an orthopedic surgeon from Rancho Los Amigos, CA, demonstrated through pictures people being admitted to their facility were terribly medically mismanaged. These patients were public and private, those people who had supposedly the availability of the finest medical care in the United States. So, there is some way to go in terms of training.

We have fought these concerns in terms of eligibility, access, training to HCFA over the years. To date we have really had no effective response from HCFA. We would appreciate the committee directing HCFA to intervene in these areas of eligibility, access, and training which we feel would be helpful to our constituency.

We know that this committee is interested very much as we are in the quality of life for disabled people. We know that because you have been our partners in our work over the last few years. We have to ask ourselves as we begin to establish trauma centers nationwide are we ready to commit the resources necessary to rehabilitate these people over time. If not, then we have to ask ourselves if these lives we are saving are being fully served. The foundation knows that they can be fully served through long-term rehabilitative care, and we would appreciate your support in a few areas. No. 1, today unfortunately prevention is the only cure for head injury, and we would be remiss if we did not ask for funding of the request for the National Highway Traffic and Safety Administration and Centers for Injury Control's budgets with regard to prevention.

PREPARED STATEMENT

Finally, in closing we hope that the committee will support the funding levels for programs under HHS and the Department of Education as recommended by the Consortium for Citizens with Disabilities and the National Committee on Research.

Thank you very much.

Senator Adams. Thank you very much. I am somewhat familiar with that problem with the National Traffic Safety Board. I went to the Supreme Court three times as Secretary of Transportation to try to get seat belts in, as you remember, and then to get air bags in. And, finally, something is happening. But I agree with you completely that the prevention program—I am staggered by how long it took us to move to that point, and I am saddened by it.

Thank you, Mr. Goggins, very much for your testimony. I have made some notes to Senator Harkin, and he and I will discuss that because I do have some background in that area too as former secretary.

Mr. Goggins. I know, Senator. Thank you so much.

Senator Adams. Thank you.

[The statement follows:]

STATEMENT OF TIMOTHY J. GOGGINS

Mr. Chairman, my name is Tim Goggins, I am the Director of Development of the National Head Injury Foundation, and I am here testifying on behalf of our President Marilyn Price Spivack and the foundation. I would like to thank you and the members of the committee for allowing me to be here today. I would especially like to thank the Committee for your support over the years, particularly your efforts on the establishment of the Interagency Task Force on Head Injury.

Currently, we are eagerly awaiting a report, now overdue from the Interagency Task Force. It is my understanding that the report has yet to be released by Dr. Sullivan. We would certainly appreciate this Committee's support in pressuring HHS to issue the report as quickly as possible in compliance with its scheduled publication.

We want you to know that just this week, the proceedings from the September 1987 National Institute of Disabilty Rehabilitation Research, (NIDRR) Research Conference on head injury which was held in September 1987 was published and is ready for distribution. The book will be an important resource for this Committee and will enhance the Interagency Report.

Today, as in each year since we first testified in 1982, the concern of the NHIF revolves around the issues of access and quality of care available for victims of traumatic brain injury (TBI). It has been our pleasure to work with the members of this committee over the years to promote access to a continuum of care for all those with TBI. But the challenge still remains. You see, most Americans do not have access because coverage is not available and eligibility criteria is a major barrier.

Despite Congressional intent to provide services as stated in the Developmental Disability Act, "necessary to enable persons to achieve their maximum potential through increased independence, productivity and integration into the community", funding for long term care to rehabilitate those with TBI is sporadic to non-existent nationally.

The NHIF is particularly concerned with access to service because of funding gaps and eligibility barriers which discriminate on the basis of age and disability, and with traditional testing criteria which focus on mental retardation. Compounding the problem, is the lack of awareness of the long term potential for rehabilitation. Even today, this problem exists among too many physicians, psychiatrists and psychologists who should be better trained in medical management and rehabilitation after initial trauma care.

At a recent international head injury conference this past month an orthopedic surgeon from Rancho Los Amigos hospital, treating head injury and spinal cord showed slides of patients coming into their facility. The complications in the photographs were seen in patients at all levels of society, including those who had access to the "finest" in private medical care. We have requested these photos for this testimony so we could share our horror in the unnecessary added suffering and cost associated with this type of medical mismanagement. What these pictures depict is medical care so poorly administered as to affect increased life-long disabilities.

We have approached HCFA over the years to begin to intervene in the development of regulations, coding, professional training and funding mechanisms directed to this population as they have for other newly identified diseases and disabilities. To date there has been no response to these requests. That is why we are now requesting this committee to direct the Health Care Finance Administration (HCFA) and all pertinent agencies to intervene in the areas of eligibility, tracking and data collection to identify research, training and service needs, and the short and long terms costs which impact the individual and society.

We know the members of this committee are truly interested in the quality of life for people who are disabled and chronically ill. We know because you have been our partners in our work. As we promote the establishment of trauma centers, we must now ask ourselves if we are willing to commit the resources to provide access to a continuum of quality medical care and the necessary long term rehabilitation which maximizes the quality of life. If not, our initial investment in saving lives is not serving those whose lives are saved. The Foundation knows now that appropriate medical management and rehabilitation is a good investment because the fortunate few who have access to the system of brain injury care we helped develop, have achieved their maximum level of function.

We ask this Committee to again support the funding level of the Consortium for Citizens With Disabilities and to encourage the release of the Interacency Task Force report which addresses all of the issues we have talked about today and more. We look to you to find new funds to give life to the language included in the NHIF Office of Special Education and Rehabilitative Services agreement.

We would be remiss if we did not also request your support for funding for prevention initiatives undertaken by NHTSA and the Centers for Injury Control. Right now prevention is the only cure for TBI and the NHIF is committed to all prevention research, training, and education initiatives.

As the subject of animal research is considered in the Congress, the NHIF feels it necessary to take a position on this issue. While there is no doubt that most of us care deeply about animals, we also care about persons who have sustained head injuries, and the fact remains that every major medical breakthrough of the last centruy has involved research with animals. The Foundation endorses only careful studies that observe traditional compassionate ethics of animal experimentation.

In closing we hope that the committee will support the funding levels for programs under HHS and the Department of Education as recommended by the Consortium for Citizens With Disabilities and the National Committee on Research.

STATEMENT OF SUSAN GALBRAITH, NATIONAL COUNCIL ON ALCOHOLISM, INC.

Senator ADAMS. Now, let's see. Our next witness is Susan Galbraith, the National Council on Alcoholism. I'm sorry that you had to wait, but we did want to accommodate the witnesses and you were most kind to do so.

Ms. GALBRAITH. That's fine.

Good morning, Senator Adams. My name is Susan Galbraith and I am representing the National Council on Alcoholism. I ask that my full written testimony be submitted for the record, and I will summarize.

Senator ADAMS. Without objection, the testimony will be included in the record in full as if read.

Ms. GALBRAITH. Thank you.

One of Government's highest callings beyond the preservation of individual liberties of its citizens is the preservation of their health and safety. No other disease in America, no other force is so destructive to health and safety as the diseases of alcoholism and other drug addictions. The failure to adequately fund the national effort to prevent and treat alcoholism and drug addictions is a failure to adequately address the needs of America and at the same time to betray the hopes and health of tens of thousands of Americans affected directly or indirectly by this devastating illness.

A failure of nerve to adequately fund the alcohol, drug abuse, and mental health services block grant, which serves as the primary source of prevention and treatment funding to the States, will be a tragic fulfillment of democracy's greatest danger that the needs of the underserved populations and unpopular social segments will be unchampioned and, therefore, abandoned.

NIAAA and NIDA are the research backbone of the Nation's commitment to reduce the toll of alcohol and other drug problems. NCA supports $358.1 million for NIDA research and $138.7 million for NIAAA research. We join with other leading organizations in the alcohol, drug abuse, and mental health fields in requesting a higher level of appropriations for the ADMS block grant at $1.6 billion.

NCA supports the continuation of the women's set-aside of the ADMS block grant, $8.9 million for AIDS research at NIAAA, $17 million for support of the NIAAA homeless demonstration programs, and support of OSAP's new demonstration projects for pregnant and postpartum alcohol and drug dependent women and their infants, programs which reach out and serve underserved populations.

In addition, NCA supports an appropriation of $154.3 million for the Office of Substance Abuse Prevention, including a full $15 million for the important pregnancy demonstrations. This demonstration will bring to bear the first programs in this country for pregnant alcohol and drug dependent women. Women who are pregnant and drug dependent virtually are barred from service across the country.

Finally, ADAMHA has coordinated the Federal effort since 1973. Under this important umbrella agency, significant progress has been made. It is critically important, therefore, for ADAMHA to remain the lead Federal agency and that treatment service programs not be assigned elsewhere in the Public Health Service. To do otherwise, will be to fragment Federal efforts and to reduce the effectiveness of the dollars spent.

PREPARED STATEMENT

Mr. Chairman, the National Council on Alcoholism is pleased to pledge its continued support for Federal alcohol and other drug research prevention and treatment activities.

Thank you for your concern and commitment and for the opportunity to speak with you this morning.

[The statement follows:]

STATEMENT OF SUSAN GALBRAITH

The National Council on Alcoholism is the leading voluntary health organization working nationwide to prevent and reduce alcoholism and other alcohol and drug related problems.

NIAAA and NIDA represent the research backbone of the federal commitment to reduce the toll of alcohol and other drug problems. The Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant serves as the primary source of prevention and treatment funding to states, funds which are translated into public alcoholism and other drug prevention and treatment services in communities across the nation. The ADMS block grant was greatly enhanced under the Anti-Drug Abuse Act of 1988 and full funding for these programs will provide important relief to the states who are faced with the challenge of treating alcoholics and drug dependent individuals in communities. The Office for Substance Abuse Prevention (OSAP) is leading the nation in supporting prevention efforts in communities across America. Finally, the NIAAA Homeless Demonstration Projects funded under the Stewart B. McKinney Homeless Assistance Act are providing direct services to homeless individuals who are alcoholic and drug dependent while providing important research on treatment outcome and effectiveness.

NCA would like to underscore the importance of maintaining a federal focus on alcohol and drug prevention, treatment and research. ADAMHA has coordinated the federal effort since 1973. Its role was enhanced by many provisions of the Anti-Drug Abuse Act of 1988, and particularly the new centralized data collection function under the ADMS block grant. It is critically important for ADAMHA to remain the lead federal agency, and that treatment services programs not be assigned elsewhere in the Public Health Service.

NCA lends its support to the appropriations numbers recommended by the AD Hoc Coalition on National Alcohol and Drug Issues, an organization representing 30 national organizations concerned about alcohol and drug problems. Those recommendations include an appropriation level of $358.1 million for NIDA research, $151.4 million of which will be devoted to AIDS research, and $154.3 million for OSAP, which includes $114.3 for demonstration projects.

National Institute on Alcohol Abuse and Alcoholism

Historically, the NIAAA research budget has paled in comparison to federal research efforts for other illnesses, despite alcohol's very substantial contribution to mortality and morbidity and an annual economic toll on the nation of well over $116 billion. Recent increases in the NIAAA budget must be continued if the "War on Drugs" is to begin to effectively address the nation's leading drug problem -- alcohol.

The National Council on Alcoholism encourages the Subcommittee Members to appropriate $138.7 million for the NIAAA's research budget. This would allow for new and competing research grants. NCA supports a comprehensive approach to research. NIAAA research must go beyond biomedical concerns and evaluate various approaches to the prevention and treatment of alcoholism and alcohol related problems. A study is needed to explore the ethical issues and implications of genetic research. Critical questions about environmental factors which contribute to alcoholism and other alcohol problems, including price and availability merit further exploration and federal resources.

NCA supports an appropriation of $8.9 million for AIDS research to be conducted at NIAAA. This research should focus on the relationship between alcohol use and high risk behavior and the role of problem drinking in spreading HIV infection. In addition, NCA supports an appropriation of $5.5 million for research training and $11.6 million for direct operations.

In the area of special Institute initiatives, NCA urges the Subcommittee to appropriate $17 million for support of the NIAAA/NIDA Homeless Demonstration Programs, as requested by President Bush. We respectfully request that appropriated funds for this critical program remain available, until expended. Further, we urge the Committee to articulate in report language the Committee's intent that this program be maintained at NIAAA with a strong dual focus of service provision and research and evaluation. This appropriation will support the establishment of a minimum of 18 new model demonstration programs.

Alcohol, Drug Abuse and Mental Health Administration

The National Council on Alcoholism requests an appropriations level of $1.6 billion for the ADMS block grant. The national focus on the nation's drug crisis has brought into sharp relief the inadequacy of the nation's public treatment system to serve all of those individuals seeking treatment for alcoholism and other drug dependencies. Waiting lists for individuals seeking treatment are common in many states. The AIDS crisis has exacerbated this situation. The block grant provides desperately needed funds to support state efforts to serve the needs of alcohol and drug dependent individuals. In many cases, these funds serve those without medical insurance and the indigent. It is imperative that appropriations for the block grant remain high if the national need for adequate data and the escalating demand for treatment services are to continue to be met.

NCA supports the continuation of the women's set-aside of the ADMS block grant. The set-aside amount was raised in the Anti-Drug Abuse Act of 1988 from 5 percent to 10 percent. The set-aside provision requires that states use this money to establish prevention and treatment efforts designed specifically for women. We urge that states be required to follow the mandate established by the law and use these funds appropriately.

Office for Substance Abuse Prevention (OSAP)

NCA applauds the work of OSAP. OSAP is leading the nation in our efforts to prevent and reduce alcohol and drug related problems. NCA is especially pleased to see OSAP's new demonstration projects for pregnant and postpartum alcohol and drug dependent women and their infants. The need for action to identify and provide services to pregnant women with alcohol and other drug problems is substantial and urgent. Incidents of pregnant women with alcoholism and other drug addictions being charged with criminal offenses are increasing. Punitive measures including termination of parental rights and incarceration are on the books, despite the virtual absence of treatment opportunities for this population in every region of the country. This modest demonstration -- funded at $4.5 million for fiscal year 1989 -- will begin a national focus on a tremendously underserved population. NCA urges the Subcommittee to appropriate $15 million for this project for fiscal year 1990.

The National Council on Alcoholism is pleased to pledge its continued support for federal alcohol and other drug research, prevention and treatment initiatives. A strong federal commitment beginning in the early 1970's has made great gains in alcoholism and drug research, prevention and treatment possible. A continuation and enhancement of that commitment are essential to progress.

Senator **Adams**. Thank you very much.

I have simply one question. Most recently in my examination of this, we have one very large lawsuit pending, mother to child, and, of course, we have both the AIDS problem and the drug addiction problem of babies transmitted through mothers. I assume that your direction in the particular research program you feel that there is a substantial opportunity for us to receive an answer to this.

Ms. **Galbraith**. An answer to how to address——

Senator **Adams**. Whether or not this is happening and the degree to which it is happening. It is rather—I guess the best way you could put it that many people are looking at this and saying, oh, my God, is this what really is happening. And we're getting everything strained through a lawsuit, and as a former lawyer, I can tell you that when things are strained through a lawsuit, the mix comes out exceedingly fine rather than as a research project.

Ms. **Galbraith**. Well, I'm very familiar with the lawsuit in Seattle that is being tried right now. It's unclear what the outcome of that will be. My colleague is there testifying in that case.

Senator **Adams**. Well, I would appreciate if you might submit to the committee from your organization in written form any suggestions and comments on treatment that you may have because we do not want to base potential public policy on the results of one suit. But I must say that the testimony in that lawsuit is—I was going to say someplace between confusing and horrifying.

For those of you who are not familiar with this, this is the lawsuit filed by a mother whose child has been affected with the syndrome that you receive from excessive use of alcohol. The question is she drank certain amounts of alcohol up to a fifth—half a fifth to a fifth of bourbon a day during the course of her pregnancy, and she is suing the Jim Beam Co. for having caused this and saying there should be a warning on the bottle. So, I anticipate that that will be a series of things that will come up, and I just don't want to rely on the results out of the lawsuit alone. That is why I am asking you and others that are witnesses here. We need the best information that we can get on this.

Ms. **Galbraith**. That's right. Let me just add that I'm formerly a service provider to alcohol and drug dependent women and their kids for about 10 years. Services in this country for alcohol and drug dependent women who are pregnant are virtually nonexistent. They just are not there.

The pregnancy demonstration project through the Office for Substance Abuse Prevention will be the first effort to really establish meaningful services. I think we need to really support that effort and watch that very carefully. Women have had no opportunity for treatment during their pregnancies, and that is where we have really let women down who are pregnant and in need of services.

Senator ADAMS. A second area that you might focus on because I will be interested in the oversight of it is that the Mayor of Washington, DC, testified yesterday that they have finally established immediate access at Washington General Hospital for pregnant women suffering from either substance abuse in the drug area—and I did not remember whether he testified in the alcohol area. I assume your organization will be focused on it. It is an area certainly where you have the clientele and patients available. We would like to know the results of that.

Ms. GALBRAITH. I am very familiar with the District of Columbia case and access to care.

Senator ADAMS. I assume that you would be.

Ms. GALBRAITH. So, I would be happy to comment on that.

Senator ADAMS. I don't want us to jump at some of these things, but I don't want us to let them lie fallow either.

Ms. GALBRAITH. The good news is that there are organizations in the District of Columbia who are applying for the pregnancy demonstrations. So, we may have an opportunity to establish some meaningful services in the District of Columbia.

Senator ADAMS. Thank you very much. We appreciate your testimony.

STATEMENT OF BARRY A. EDELSTEIN, PH.D., CHAIR, COUNCIL OF UNIVERSITY DIRECTORS OF CLINICAL PSYCHOLOGY

Senator ADAMS. Our next witness is Barry Edelstein, Council of University Directors of Clinical Psychology. Dr. Edelstein, welcome to the committee.

Dr. EDELSTEIN. Thank you. I would like to summarize my testimony this morning and have the full testimony entered into the record.

Senator ADAMS. Without objection, the testimony will appear in full as though given in the record, and you may proceed with the summary. Welcome to the committee.

Dr. EDELSTEIN. Mr. Chairman and members of the subcommittee, I appreciate this opportunity to present testimony on the subject of the fiscal year 1990 appropriations for the National Institute of Mental Health, NIMH, clinical and research training programs. I am Dr. Barry Edelstein, a clinical psychologist on the faculty of West Virginia University, and a consultant for a long-term care geriatric facility. I am also chair of the Council of University Directors of Clinical Psychology, an organization which represents over 80 percent of the approximately 170 clinical psychology programs in the United States.

With regard to NIMH clinical training programs, while the Bush administration budget is unclear in its funding recommendation for the program, the Reagan administration budget for fiscal year 1990, consistent with the budget proposals of previous years, requested only $8 million for the clinical training program and proposed that the program be phased out over a 3-year period beginning in fiscal year 1990.

Senator **Adams**. When you say unclear, you refer to this as being one of the programs that is in the so-called black box.

Dr. **Edelstein**. Yes.

The Council of University Directors of Clinical Psychology opposes this request. We strongly support continued and increased funding at $26 million for NIMH clinical training activities in fiscal year 1990. This recommendation is also supported by the Mental Health Liaison Group, a coalition of more than 40 consumer, provider, professional, scientific, and citizen advocacy organizations.

The NIMH provides the major source of the Nation's mental health clinical training funds. The program has supported trainees in psychology and the other three core mental health professions, psychiatry, social work, and psychiatric nursing, in every State and provides critical support for the training of professionals who are properly equipped and skilled to provide mental health services to priority populations.

Congress has consistently rejected the administration's efforts to eliminate the clinical training program over the past 9 years. We have appreciated your support and the wisdom of your efforts to redirect the clinical training programs toward the training of mental health providers who can meet the needs of still underserved priority populations, the chronically mentally ill, children and youth with serious mental illness, elderly individuals with mental disorders, and minority and disadvantaged groups.

For fiscal year 1990 and beyond, the council recommends increased emphasis on clinical training directed toward specific underserved population groups in underserved areas by expanding the number of student trainees who incur a service obligation including those students supported through the minority fellowship program. In this regard, we applaud the recent $3 million institutional clinical training grant announcement that focuses on the targeted clinical populations and on the training of minority students and which is responsive both to the council's concerns as well as those of Congress.

To ensure further the accountability of the clinical training program, the council recommends elimination of the payback exemption for short-term training and equitable distribution of program funds among the four core mental health professions. Psychology, for example, supplies 30 to 40 percent of all trainees who incur a payback obligation for service in a priority area, but receives only 10 percent of all clinical training funds. A more equitable distribution of program funds would help to ensure that taxpayers receive the maximum return on their investment in this program.

Finally, the council would like to see NIMH conduct a study on projected shortages of mental health personnel. Data on the number of professionals needed to provide services to the priority populations are not now available, and that lack of information threatens to compromise the ability of NIMH to meet their responsibilities. We urge you to consider this issue.

Finally, research training. The council is concerned with adequate funding for the NIMH research training program in fiscal year 1990. One of the unique aspects of the training of clinical psychologists is that our model for training integrates research and clinical skills. The result of such training model is that the clinical psychologist is skilled in evaluation and quality of care issues as well as the delivery of services and the research psychologist is prepared to study important clinical problems.

PREPARED STATEMENT

The number of research trainees supported by NIMH has declined steadily over the past 8 years from 1,300 trainees in fiscal year 1981 to a projected low of 954 trainees this year. This consistent decrease in numbers of research trainees funded by NIMH will make it increasingly difficult to ensure an adequate supply of well-trained mental health researchers who bring new intellectual capital to the field in the future. Because the research training effort is in serious jeopardy, we urge an appropriation of $43.6 million for NIMH research training.

Thank you for the opportunity to testify on behalf of the Council of University Directors of Clinical Psychology and NIMH.

Senator ADAMS. Thank you, Dr. Edelstein, very much for your testimony. I appreciate that.

[The statement follows:]

STATEMENT OF BARRY A. EDELSTEIN

Mr. Chairman and Members of the Subcommittee, I appreciate this opportunity to present testimony on the subject of fiscal year 1990 appropriations for the National Institute of Mental Health (NIMH) clinical and research training programs. I am Dr. Barry Edelstein, a clinical psychologist on the faculty of West Virginia University, and consultant for a long-term care geriatric facility. I am also Chair of the Council of University Directors of Clinical Psychology, an organization which represents over 80 percent of the approximately 170 clinical psychology programs in the United States.

NIMH Clinical Training Program

While the Bush Administration budget is unclear in its funding recommendation for the program, the Reagan Administration budget for FY 1990, consistent with the budget proposals of previous years, requested only $8 million for the clinical training program and proposed that the program be phased out over a three-year period beginning in FY 1990. The Council of University Directors of Clinical Psychology opposes this request. We strongly support continued and increased funding at $26 million for NIMH clinical training activities in FY 1990. This recommendation is also supported by the Mental Health Liaison Group - a coalition of more than 40 consumer, provider, professional, scientific, and citizen advocacy organizations.

The NIMH provides the major source of the nation's mental health clinical training funds. The program has supported trainees in psychology and the other three core mental health professions -- psychiatry, social work, and psychiatric nursing -- in every state, and provides critical support for the training of professionals who are properly equipped and skilled to provide mental health services to priority populations.

Congress has consistently rejected the Administration's efforts to eliminate the clinical training program over the past nine years. We have appreciated your support and the wisdom of your efforts to redirect the clinical training program toward the training of mental health providers who can meet the needs of still underserved priority populations: the chronically mentally ill, children and youth with serious mental illness, elderly individuals with mental disorders, and minority and disadvantaged groups.

We believe that this redirection is not only appropriate but also is the best way to invest limited federal resources. Demographic projections suggest that there will be steady increases in the numbers of persons, particularly among the elderly and ethnic minority groups, suffering from schizophrenia and other serious mental disorders, and multiple coexisting medical and psychiatric conditions. Moreover, it has been documented that 3 million children and adolescents currently are in serious need of mental health services, but only about 1 million receive needed treatment. While there have been substantial increases in the numbers of trained mental health professionals over the past two decades, it would be very shortsighted to conclude special efforts are no longer needed to address the nation's mental health manpower needs.

For FY 1990 and beyond, the Council recommends increased emphasis on clinical training directed toward specific underserved population groups and underserved areas by expanding the number of student trainees who incur a service obligation, including those students supported through the Minority Fellowship Program. In our view, the single most effective mechanism for addressing the shortage of mental health professionals serving priority populations is the "payback" provision of the clinical training program. This statutory provision requires all trainees in psychology, psychiatry, social work and nursing who receive stipends for long-term graduate training to repay this direct support through service delivery in a mental health shortage area or with an underserved population. As of October 1987, nearly 2500 graduate mental health professionals in the four core mental health disciplines had practiced or will practice in public facilities with priority populations or perform some other acceptable public service. In this regard, we applaud the recent $3 million institutional clinical training grant announcement that focuses on the targeted clinical populations and on the training of minority students, and which is responsive both to the Council's concerns as well as those of Congress.

To ensure further the accountability of the clinical training program, the Council recommends elimination of the payback exemption for short-term training, and equitable distribution of program funds among the four core mental health professions. Psychology, for example, supplies 30 to 40 percent of all trainees who incur a payback obligation for service in a priority area, but receives only about 10 percent of all clinical training funds. A more equitable distribution of program funds would help to ensure that taxpayers receive the maximum return on their investment in this program.

Finally, the Council would like to see NIMH conduct a study on projected shortages of mental health personnel. Data on the number of professionals needed to provide services to the priority populations are not now available, and that lack of information threatens to compromise the ability of NIMH to meet their responsibilities. We urge you to consider this issue.

Research Training

The Council is concerned with adequate funding for the NIMH research training program in FY 1990. One of the unique aspects of the training of clinical psychologists is that our model for training integrates research and clinical skills. The result of such a training model is that the clinical psychologist is skilled in evaluation and quality of care issues as well as the delivery of services, and the research psychologist is prepared to study important clinical problems. The number of research trainees supported by NIMH has declined steadily over the past eight years from 1,300 trainees in FY 1981 to a projected low of 954 trainees this year. This consistent decrease in numbers of research trainees funded by NIMH will make it increasingly difficult to ensure an adequate supply of well trained mental health researchers who bring new "intellectual capital" to the field in the future. Because the research training effort is in serious jeopardy, we urge an appropriation of $43.6 million for NIMH research training.

Minority Fellowship Program

Finally, the Council encourages this Committee to continue its past strong support of the Minority Fellowship Program (MFP), which is designed to support the clinical and research training of ethnic minorities in mental health fields. The American Psychological Association has participated in the MFP since 1974 and APA's MFP has emerged as a national model of graduate training opportunities for ethnic minority psychologists. The program has been a wise investment, training 11 percent of all doctoral level ethnic minority psychologists providing health and mental services. Nevertheless, the need for far greater numbers is still evident in the underrepresentation of ethnic minorities in the field of psychology and the other core mental health disciplines. Fewer than 5 percent of all Ph.D. psychologists providing health and mental health services are ethnic minorities.

Yet despite the MFP's highly successful track record, its federal funding has dropped from a high of $2.6 million in FY 1981 to roughly $1 million in FY 1989. We recommend that this Subcommittee include specific language in its report accompanying the FY 1990 appropriations bill to ensure that additional resources are devoted to this program.

Thank you for the opportunity to testify on behalf of the Council on NIMH clinical and research training appropriations.

STATEMENT OF JEAN RAMAGE, PH.D., CHAIRPERSON, THE NATIONAL CONSORTIUM FOR CHILD MENTAL HEALTH SERVICES

Senator ADAMS. There has been a request, Dr. Kupfer, that we might wait with your testimony until Senator Byrd has arrived at the committee because he would like to be present. So, therefore, our next witness will be Jean Ramage of the National Consortium for Child Mental Health Services.

I apologize. Senator Byrd is chairman of the committee. He has requested this for Senator Specter. So, I am reading too quickly off the notes. My apologies to the States of Pennsylvania, West Virginia, and to the two affected Senators. [Laughter.]

Dr. RAMAGE. Thank you.

I am Jean Ramage, and I am here today representing the Consortium for Child Mental Health Services. We want to focus on the child and adolescent service system program which is one of the few programs of the National Institute of Mental Health that focuses on children.

Our group, the National Consortium for Child Mental Health Services, appreciates this opportunity to support the subcommittee and also appreciates that you have supported this program in the past.

The deficiencies in the service systems in this country have been addressed in recent years by the National Institute of Mental Health child and adolescent service system program, which we will call CASSP. The leadership of this subcommittee believed in this small program when it began in 1984 with an appropriation of only $1.5 million. In response, requests came from 44 States and territories for help in developing a strategy to better deliver mental health services for children and adolescents. In 6 years, most of those States have received help from CASSP, but the work must continue in the remaining States and communities. I am here today to ask for you to continue the support of this effective and efficient program.

The consortium was formed in 1971 to inform and promote understanding about the emotional disturbances of children under age 18 and the special services they require. All of the members are national, consumer, professional, and provider organizations. We probably represent over 1 million people. We meet quarterly to review the state of mental health services for children and adolescents and to act on issues needing unity and national information and education strategies.

The consortium members have presented the statistics of children and adolescents with emotional disturbance many times, and the numbers have not diminished. At least 7 to 12 million youngsters under the age of 18 are in need of mental health care at any given time; 3 million of those children are seriously emotionally disordered. A 1982 survey estimate indicated that only one-third were receiving appropriate treatment.

In response to that assessment, the National Institute of Mental Health proposed the child and adolescent service system program and Congress approved the first appropriation for fiscal year 1984.

CASSP is a strategy development program to improve systems for service delivery to children and adolescents with severe emotional disturbances.

CASSP is part of the National Institute of Mental Health service demonstration projects. It became part of the new National Institute of Mental Health child and family support branch last year and is coordinated with demonstration programs serving youth and adults.

Each appropriation since 1984 has allowed the CASSP program to continue to be a rallying point for the innovative use of modest funds, common sense planning, and controlled growth. This year those 10 States funded in the first year graduated from the 5-year support program. From the final reports of these graduates will come invaluable data on the study of system development strategies.

In fiscal year 1989 the demonstration programs received an appropriation of $25.9 million, with $8.09 million of that for the CASSP program. By appropriating a total of less than $25 million for the CASSP program, Congress has brought active operation of CASSP into 40 States and 13 communities.

If the President's request for $19 million in fiscal year 1990 for all of the mental health service demonstrations is approved, it will result in no growth for the CASSP program.

Therefore, the consortium recommends an appropriation of $38.3 million for the National Institute of Mental Health service demonstrations, with $9.8 million designated for the child and adolescent service system program.

PREPARED STATEMENT

Although I can't finish all of the testimony, I would like it included in the record.

Senator ADAMS. Without objection, the entire testimony will be included in the record.

[The statement follows:]

STATEMENT OF JEAN RAMAGE

The National Consortium for Child Mental Health Services member organizations appreciate the support the Subcommittee has given to the National Institute of Mental Health (NIMH) programs providing mental health services to children and adolescents. The deficiencies in the service systems in this country have been addressed in recent years by the NIMH Child and Adolescent Service System Program (CASSP). The leadership of this Subcommittee believed in this small program when it began in 1984 with an appropriation of $1.5 million. In response, requests came from 44 states and territories for help in developing a strategy for better delivery of mental health services for children and adolescents. In six years, most of those states have received help from CASSP, but the work must continue in the remaining states and communities, and I am here today to ask you to continue your support for this effective and efficient program.

I am Jean Ramage, Ph.D., chairperson of the National Consortium for Child Mental Health Services. I appreciate this opportunity to come before you to testify about the concerns the twenty member organizations of the Consortium have for developing appropriate systems of mental health services for the children and adolescents in this country.

The Consortium was formed in 1971 to inform and promote understanding about the emotional disturbances of children under age 18 and the special services they require. All of the members are national, consumer, professional and provider organizations. We meet quarterly to review the state of mental health services for children and adolescents and to act on issues needing unity and national information and education strategies.

The Consortium members have presented the statistics of children and adolescents with emotional disorders many times, and the numbers have not diminished -- at least 7 to 12 million youngsters under age 18 are in need of mental health care at any given time. Three million of those children are seriously emotionally disordered. A 1982 survey estimate indicated that only one-third were receiving appropriate treatment.

Child and Adolescent Service System Program

In response to that assessment, NIMH proposed the Child and Adolescent Service System Program, and Congress approved the first appropriation for FY 1984. Eight states were funded in that first round of awards.

CASSP is a strategy development program to improve systems for service delivery to children and adolescents with severe emotional disturbances. The goal is to direct the service delivery in states and communities toward a philosophy of multi-agency use and inter-agency coordination. States and communities work within their current systems to improve service delivery. CASSP does not involve setting up entirely new delivery systems.

CASSP is part of the NIMH mental health service demonstrations. It became part of the new NIMH Child and Family Support Branch last year and is coordinated with other demonstration programs serving young adults with substance abuse, homeless persons with mental illnesses, and older persons with mental illnesses. The success of the CASSP program is reflected in the number of demonstration programs growing up around it to address the full range of service needs.

Each appropriation since 1984 has allowed CASSP to continue to be a rallying point for the innovative use of modest funds, common-sense planning, and controlled growth. This year, those ten states funded in the first round "graduated" from their five year support program. From the final reports of those graduates will come invaluable data for a study of system development strategies. The study will provide assessments of the state CASSP programs that generated the most effective strategies for multi-agency service system programs.

In FY 1989 the demonstration programs received an appropriation of $25.9, with $8.09 million of that for the CASSP program. By appropriating a total of less than $25 million for the CASSP program, Congress has brought active operation of CASSP into forty states and thirteen communities. It has brought coordinated, useable technical assistance into those states and set up two research and training centers that also provide a clearinghouse of CASSP related information.

Three special initiatives have been developed within the CASSP program -- the Minority Initiative, the Families as Allies project, and the High Risk Program for addressing the issue of homeless children and adolescents and children at risk for AIDS, are well underway but need continued support to reach into the established service systems. Refugee children and adolescents also receive a special focus in order to help CASSP grantees assure their inclusion in the service system program.

CASSP is the strongest link we have that protects children with emotional disorders from falling through cracks in the service system. With each modest grant, severely emotionally disturbed children and adolescents can be linked with available services in health care, mental health, education, special education, housing, and other support programs, such as nutrition, where there is eligibility. This program specifically responds to the assessments of what is needed to help coordinate agencies. It has begun its work, but it is far from finished. The community projects are just beginning and the special initiatives have not realized their potential.

If the President's request for $19 million in FY 1990 for all of the mental health services demonstrations is approved, it would result in no growth for the CASSP program, no funds for assessing what has been accomplished, and no data to direct future strategies for delivery systems. Each area of funding for CASSP is designed to provide higher efficiency for the network of agencies serving children and adolescents. This efficiency means better, more appropriate mental health treatment for youngsters in this country.

The Consortium recommends an appropriation of $38.3 million for the NIMH mental health services demonstrations, with $9.8 million designated for the Child and Adolescent Service System Program.

Thank you again for this opportunity to testify before the Subcommittee. Members of the Consortium appreciate this opportunity to speak in support of a modest grant program that has had remarkable results in just six years.

Senator ADAMS. We thank you very much for your testimony, Dr. Ramage.

I hope that there is some focus—and perhaps you may want to include some written reference. I personally am concerned, and I know a number of Members of the Senate and the House are, at the child suicide rate in high school. For example, I visited 3 weeks ago a rural high school, a small town in the State of Washington. They had five child suicides since the beginning of the year, some drug connected, some connected with others. We just don't have any handle on this.

Dr. RAMAGE. This is the only program in the National Institute of Mental Health for children. If you look at the proportion, you can see how little it is. There are few funds that trickle down through the Office of Special Education, but there is no place to go. I'm a school psychologist, and I can tell you that five in a high school is typical around the country. It's not unusual.

Senator ADAMS. That's what I wanted to have you submit some information on. I have no direct evidence, but I have it in the sense of a nationwide survey. But I am very concerned. I find this turns up in more and more high schools. I mentioned the type of school. This is not an inner-city school. This is more of a rural area. I want to know the degree to which it is endemic. We may be losing a lot more children than we are aware of.

Dr. RAMAGE. Thank you very much.

Senator ADAMS. Thank you, Dr. Ramage.

STATEMENT OF ROBERT PERLOFF, PH.D., AMERICAN PSYCHOLOGICAL ASSOCIATION

Senator ADAMS. Our next witness is Dr. Robert Perloff, American Psychological Association. Dr. Perloff, welcome to the committee.

Dr. PERLOFF. Thank you. Sitting here before you this morning, Mr. Chairman, I am reminded with some pleasure and great nostalgia that during World War II, I served in Ft. Lewis, WA, as a GI. And you reminded me of this.

Senator ADAMS. I didn't ever make it to Ft. Lewis. I was all up and down the coast with most of my time in San Francisco and Chicago in the Navy. But welcome. I hope you enjoyed Ft. Lewis.

Dr. PERLOFF. I did. I would like our full testimony to be part of this record if that's possible, Mr. Chairman.

Senator ADAMS. Without objection, the entire testimony will appear in full in the record at this point.

Dr. PERLOFF. Thank you, sir. Mr. Chairman and members of the subcommittee, I am Dr. Robert Perloff, professor of business administration and psychology in the Katz Graduate School of Business at the University of Pittsburgh. I am past president of the American Psychological Association [APA], a scientific and professional organization representing over 90,000 psychologists in the United States.

Mr. Chairman, I am here today on behalf of APA to ask that your subcommittee support our funding recommendations to advance the Federal investment in ADAMHA research training and services programs. This commitment is essential to improving the quality of life for the 30 to 45 million Americans who suffer from mental or addictive disorders.

In view of this need, we are very concerned about the administration's proposed flexible freeze on certain programs at ADAMHA. Under this proposal, funding for many of ADAMHA's non-AIDS research programs could be increased only at the expense of others being decreased. Given that ADAMHA supports more than 90 percent of the Nation's biomedical and behavioral research on alcohol and drug abuse and mental health, this proposal poses a serious threat we believe to the stability of research in these areas.

The generous investment in recent years by Congress and the NIMH research program has been wise indeed. Our knowledge base in understanding mental disorders has been vastly expanded. We are on the verge of further breakthroughs in unraveling the complex mechanisms underlying depression, anxiety disorders, schizophrenia, and other major mental disorders, interpreting the interface between brain function and human behavior and enhancing our understanding of linkages between behavioral and risk factors and specific mental and physical disorders. We urge the subcommittee to keep the NIMH research program on a forward track by approving $405 million for NIMH non-AIDS research in fiscal year 1990.

Vigorous support must also be provided by Congress for the work of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. We have learned through research that both drug abuse and alcohol abuse and alcoholism are widespread problems arising from a complex interplay of biological, psychological, and environmental factors. We know that the incidence of substance abuse and the number of new drugs being used is greater than ever. Through basic research, we can enhance our understanding of what causes drug dependencies and reinforces drug-craving and drug-using behavior and improve our ability both to treat and prevent drug abuse.

Further, research on the behavioral determinants of alcoholism has revealed psychological and environmental factors contributing to this complex disorder. Yet, fluctuations in funding seriously jeopardize the effectiveness of an aggressive research effort in these areas.

To ensure stability in growth in alcohol and drug abuse research, we recommend $172 million for NIDA and $138 million for NIAAA in fiscal year 1990 for non-AIDS research.

Over the years the ADAMHA research training effort has been seriously eroded by inadequate funding and the cumulative effects of inflation, rising tuition, and other educational costs. The successive behavioral and biomedical research on mental disorders and alcohol and other drug abuse depends on a continual infusion of new ideas from young and innovative scientists. However, between fiscal year 1981 and fiscal year 1989, the number of trainees supported annually by ADAMHA dropped from 1,423 to 1,170.

PREPARED STATEMENT

To prevent a shortage of biomedical and behavioral research scientists, APA recommends $43 million for NIMH, $6 million for NIDA, and $5.5 million for NIAAA in fiscal year 1990 to begin to restore support of the Institute's research training programs.

Thank you, Mr. Chairman, for the opportunity to present the views of the American Psychological Association on these important issues.

[The statement follows:]

STATEMENT OF ROBERT PERLOFF

Mr. Chairman, Members of the Subcommittee, I am Dr. Robert Perloff, Professor of Business Administration and Psychology in the Katz Graduate School of Business at the University of Pittsburgh. I am past president of the American Evaluation Association and have been involved in the evaluation of mental health programs. I have also served as a member of several review panels for the National Institute of Mental Health (NIMH). As past president of the American Psychological Association (APA), a professional and scientific organization representing over 90,000 psychologists in the United States, I am pleased to testify today on the subject of fiscal year 1990 appropriations for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

The funding levels advocated by APA for specific programs at ADAMHA were developed in concert with the Mental Health Liaison Group - a coalition of over 40 diverse organizations involved in alcohol, drug abuse and mental health services delivery, research, education and training. We share a common purpose in working together to improve the quality of life for the 30 to 45 million Americans who suffer from mental or addictive disorders, and to reduce the associated health and economic costs which exceed $185 billion annually. We believe that a quantum leap forward in the federal investment in ADAMHA research, training, and services programs is essential to arrest this terrible drain on human and economic resources.

Recognizing this need, we are very concerned about the Administration's proposal in the FY 1990 budget to impose a "flexible freeze" on certain programs at ADAMHA. Under this proposal many of ADAMHA's non-AIDS research programs would be funded under a formula in which programs can be increased only at the expense of others being decreased. Given that ADAMHA supports more than 90 percent of the nation's biomedical and behavioral research on alcohol, drug abuse and mental health, this proposal poses a serious threat to the stability of research in these areas. Further, APA believes that providing exemptions for certain other research agencies demonstrates a lack of support for the ADAMHA research agenda, which addresses our nation's serious mental health and substance abuse problems. We find this unequal treatment unacceptable and urge you to consider our funding recommendations and to oppose the "flexible freeze."

NIMH RESEARCH

APA recommends $405 million for NIMH Research (excluding AIDS research) in FY 1990. This amount represents the best scientific and professional judgement of the needs of behavioral, biological, and social research at this juncture of knowledge and opportunity in the mental health field. Rapid advances in our present knowledge of depression, schizophrenia, and other major mental health disorders are an inevitable result of an accelerated federal investment in the NIMH research program.

We applaud and appreciate the work of the Subcommittee last year which resulted in increased funding for the (non-AIDS) research portfolio at NIMH. APA urges this Subcommittee to keep the NIMH research program on a forward track by again approving a substantial increase, above the $331 million needed to maintain current services. This action would be in keeping with the findings of the 1985 Institute of Medicine (IOM) report, "Research on Mental Illness and Addictive Disorders," which concluded that research studies on mental and addictive disorders need to be doubled to take advantage of the rapidly emerging research opportunities in these fields.

A significant increase in real spending is also needed to speed the implementation of exciting and long-awaited new initiatives in FY 1990 targeted toward schizophrenia and the neurosciences. The historic and comprehensive "National Plan for Research for Schizophrenia", issued this past year by NIMH and its National Advisory Mental Health Council, focuses on the possible behavioral and biological causes of schizophrenia, and on ways in which this disorder can be prevented. The contributions that psychologists are making in schizophrenia research parallel our increasing awareness that a complex combination of psychological, social and genetic factors contribute to the development of this disorder.

Similarly, fueled by the "Decade of the Brain" initiative, spearheaded by Congressman Conte, we can build upon our rapidly developing knowledge of brain development, learning and memory processes, emotion, cognition, and more. Here, too, psychologists will be intimately involved in research at the interface of brain function and human behavior and at the verge of breakthroughs related to the organization of the brain, the central nervous system, and cognitive functions.

Other priorities for additional study and support by NIMH concern research on mental disorders of childhood and adolescence; mental disorders of the elderly, including the psychosocial aspects of dementia; research on antisocial and violent behavior, including anti-gay violence; research on linkages between behavioral risk factors and specific mental and physical disorders and diseases; and research on anxiety disorders.

Still another increasingly important research activity carried out by the NIMH involves mental health service systems research and data collection activities. These activities include the only national source of data on the mental health service delivery system. They also include research focused on delivery systems and financing mechanisms which support the provision of mental health services. In the past, APA supported the Subcommittee's action to earmark in report language additional funds for research on issues related to the financing and delivery of services for the seriously mentally ill. We urge you to again accord special attention to this important area of research.

NIMH CLINICAL TRAINING PROGRAM

APA strongly supports the NIMH Clinical Training program at $26 million in FY 1990. The NIMH provides the major source of the nation's mental health clinical training funds, supporting in every state trainees in psychology, psychiatry, social work, and nursing. Although the Administration has persistently sought to eliminate the clinical training program over the past eight years, Congress has consistently rejected these proposals. In preserving this program, Congress has emphasized the need to target mental health services on high-priority populations and underserved individuals, such as seriously mentally disabled children and adults, ethnic minorities, the elderly and those in rural areas.

For FY 1990 and beyond, APA recommends increased emphasis on clinical training directed toward these underserved groups and underserved areas by expanding the number of student trainees who are required to work one year in a mental health shortage area or with an underserved population for each year of stipend support. In a 1986 report to Congress, the NIMH stated that "the present payback system appears to be a cost-effective method for educating mental health professionals for the future."

APA also recommends equitable distribution of clinical training funds among the four core mental health professions to further enhance the program's accountability. Psychology, for example, supplies 30 to 40 percent of all trainees who incur a payback obligation for service in a priority area, but receives only about 10 percent of all clinical training funds. A more equitable distribution of program funds would help to ensure that taxpayers receive the maximum return on their investment in this program.

NIDA RESEARCH

APA recommends $172.3 million for NIDA research (excluding AIDS). The incidence of illicit drug use and the number of new drugs being used are unprecedented. The need for research has never been greater. NIDA is the lead federal agency responsible for carrying out this mission, and through its intramural and extramural research programs supports research on the causes and consequences of drug abuse, addiction, treatment and prevention.

Psychologists with expertise in behavior, pharmacology and neurosciences, are making significant contributions to drug research. Still there remain many major gaps in our knowledge base. The need for more information, especially about alternative treatment and prevention strategies, is critical. In response to this need, as you know Congress passed the Anti-Drug Abuse Act of 1988, mandating an expansion in drug abuse research, particularly in the area of treatment and prevention. Yet, the Administration's budget request for FY 1990 is well below not only the "current services" level but is further insufficient to carry out these new research projects which were initiated in FY 1989.

In the prevention area in particular, we know very little about how to prevent occasional drug abusers from progressing to chronic use. Moreover, we are not able to distinguish those individuals who will respond to peer pressure resistance programs from those who will not. NIDA has begun to demonstrate that prevention programs can result in meaningful changes in drug-related behavior and actual drug use. Looking at the 1988 NIDA sponsored High School Senior Survey, which shows a decline in the use of illicit drugs among seniors, we need to understand the reasons for these changes in attitudes and behavior with respect to drug use and what other factors may be involved. We can then begin to identify biological, behavioral, and social indicators and precursors to drug abuse which will be useful in developing prevention programs aimed at adolescents.

Addiction research is another major part of the Institute's portfolio. With a better understanding of why certain individuals are more vulnerable to drug dependence than others, researchers will be able to identify those at risk, and develop population-specific prevention and intervention programs. And in concert with the development of new treatment approaches, researchers are recognizing the vital need to obtain information about treatment outcome.

Despite the urgency of the our nation's drug abuse problem, federal support for NIDA programs has been erratic. APA is concerned about the stability of research and how fluctuations in funding seriously jeopardize the effectiveness of an aggressive research effort. Limited and inconsistent support for research results in knowledge gaps and discourages young scientists from entering a field where evidence suggests a lack of commitment to basic research. If NIDA is to continue to make advances and set priorities for new areas, the federal government must make a long-term commitment to the Institute's growth over a number of years.

NIAAA RESEARCH

APA recommends $138.7 million for NIAAA research (excluding AIDS). As the lead federal agency responsible for reducing the health, social and economic consequences of alcoholism, the NIAAA supports a comprehensive program of extramural and intramural research aimed at developing effective treatment and prevention strategies.

Through research we have learned that alcohol abuse is a widespread problem arising from a complex interplay of biological, psychological and environmental factors. In addition to genetic-based research, progress has been made in the area of behavioral determinants of alcoholism. Even among those who are genetically predisposed to alcoholism, we now know that other psychological and environmental factors contribute to this complex disorder.

APA also supports the Stewart B. McKinney Homeless Demonstration program. With very little information available on alcoholism and the homeless population, this program is providing the needed focus. In his revisions to the FY 1990 budget request, President Bush is recommending full funding for all McKinney Act programs, specifically providing $17 million for the homeless demonstration project to be administered jointly by the NIAAA and NIDA. APA supports this recommendation.

ADAMHA AIDS RESEARCH

APA recommends $239 million in ADAMHA AIDS funding, a recommendation advanced by both the Mental Health Liaison Group and the National Organizations Responding to AIDS. As the mental health, behavioral and social science aspects of the HIV epidemic become clearer, ADAMHA has increasingly attempted to address the scope of AIDS issues relevant to their mission. Yet ongoing concerns about program balance within the Institute's AIDS portfolio remain. This 10 percent increase over the President's FY 1990 budget will support important programs that remain unfunded. The mental health demonstration program, for instance, which was authorized last year in P.L. 100-607, would be funded with this increase. The value of this program, which was designed to develop model mental health programs for persons experiencing serious negative psychological reactions to the HIV test, becomes increasingly clear in view of recent Air Force data indicating that persons testing positive may experience rates of suicide ideation 40 times higher than their peers. As a research institute and the lead agency on mental health issues in the Federal government NIMH is the most appropriate agency to administer this demonstration program.

Consistent with the recommendations of the National Research Council, our recommended funding level would allow NIMH to conduct community-based preventive intervention studies similar to the community trials conducted by NIH in heart disease and smoking cessation. OTA and GAO last year both cited the lack of good prevention evaluation data as a significant problem.

Although the scientific community is capable of conducting such work, federal leadership is needed to launch this kind of effort.

We applaud the research underway on issues such as the relationship between stress and immune system function and the neuropsychological complications related to HIV infection. APA encourages ADAMHA, however, to take seriously its role as the lead agency in the area of behavior and AIDS. Behavior change, the psychological impacts of HIV disease and the sociological context of the epidemic are all important areas of investigation for ADAMHA to pursue. More attention on the research side must also be focused on the role of drugs and alcohol in promoting high risk behavior. Moreover APA encourages full scale support for programs of outreach, education and demonstration of service delivery in the area of IV drug use and AIDS.

Finally, ADAMHA must not neglect the important role it plays in educating both scientists and clinicians in AIDS. NIMH must take seriously its Congressional mandate in P.L. 100-607 to train research scientists in psychology and the social sciences about AIDS. APA is equally concerned about the apparent retrenchment on the part of NIMH away from its promising program to fund mental health educators to conduct clinical training in mental health and AIDS. Given the success of this effort, NIMH should be directed to expand its program in this area.

RESEARCH TRAINING

APA recommends $43.6 million for NIMH, $6.0 for NIDA and $5.5 million for NIAAA. The success of behavioral and biomedical research on mental disorders and alcohol and other drug abuse depends on a continual infusion of new ideas from innovative scientists. ADAMHA research training programs strengthen the research effort by encouraging young scientists to pursue research careers in these areas.

In recent years, however, the ADAMHA research training effort has been eroded by inadequate funding and the cumulative effects of inflation, rising tuition and other educational costs. Between FY 1981 and FY 1989, the number of trainees supported annually by ADAMHA dropped from 1423 to 1170. Moreover, during that same period research training funds as a portion of

the ADAMHA budget dropped from 10% to 4%. This declining investment in research training represents a policy in contrast with what was recommended by the Institute of Medicine, which in 1985 urged that funding be increased significantly to avoid a shortfall of biomedical and behavioral research scientists.

As we plan for higher rates of attrition among senior scientists due to death and retirement and because of the long lead time needed to develop skilled researchers, APA recommends a significant increase in research training funds in FY 1990 to support 2000 research trainees at the NIMH, 228 research trainees at the NIDA and 209 research trainees at the NIAAA. This additional support will permit all three institutes to initiate training in current areas that are significantly neglected. Further, this will provide training of young investigators to develop evaluative, analytic and interpretive techniques required for research in these particular fields.

Thank you for the opportunity to present the views of the American Psychological Association on these important issues.

Senator ADAMS. Thank you, Professor Perloff. We are very concerned. I won't repeat the remarks that I made earlier to one of the other witnesses. I think that the area of research into the effects of the new drugs that are coming on the market—we mentioned crack, but there are a number of other new chemical substances, the receptor effect within the brain. It's expanding and changing so rapidly that we really don't know what we have in many areas. It is terribly destructive. So, we are very supportive of the efforts to try to deal with this problem because it is an epidemic.

Dr. PERLOFF. Well, we appreciate your deep and human concern, Mr. Chairman, for these problems.

Senator ADAMS. Thank you very much. We appreciate your testimony.

STATEMENT OF DOMINICK P. PURPURA, M.D., SOCIETY FOR NEUROSCIENCE

Senator ADAMS. Mr. Dominick Purpura. I hope I pronounced that correctly.

Dr. PURPURA. That's correct, sir.

Senator ADAMS. Dr. Purpura from the Society of Neuroscience. Glad to have you with us.

Dr. PURPURA. Senator, I would like to ask that the written statement that we prepared would be included in the record in full. And I shall try to summarize.

Senator **Adams**. The entire statement will appear in the record in full as though given, without objection. We would be pleased to hear your testimony.

Dr. **Purpura**. Thank you, sir.

I'm Dominick Purpura, and I'm dean of the Albert Einstein College of Medicine and a past president of the Society of Neuroscience that I represent.

My statement is, Mr. Chairman, quite obviously things that you have thought about.

The soul of this great Nation is being savaged by drugs, alcohol, mental illness, and child abuse all of which are disturbances of brain function. The personal and social cost of these disorders is in excess of $100 billion, but because of neglect, shame, ignorance, and denial, mental disorders are rarely adequately recognized and treated. Indeed, the Federal commitment to research is a vanishingly small fraction of the dollars appropriated for cancer and heart disease.

This desperate situation is all the more tragic because it occurs at a time of unprecedented opportunity for neuroscience investigations into the basic mechanisms underlying normal and aberrant behavior.

Drug, alcohol addiction, and mental illness have their counterparts in disturbances in the functions of nerve cells of the brain. We are persuaded that the ultimate solution to these afflictions depends upon understanding the addictive state in neurobiological terms and in finding specific neuropharmacological agents that will ameliorate abnormal brain activities.

Neuroscience research is the most cost effective approach to the management of mental illness and drug abuse. For example, the discovery of lithium as a treatment for manic depression has already saved an estimated $4 billion in the past 10 years. Clearly, the same benefits produced by lithium can be expected with other pharmacological therapies such as those for the treatment of schizophrenia providing we continue indepth studies as part of the NIMH's national plan for schizophrenia research.

We urge you to call for an end to mental illness through support of initiatives such as the decade of the brain plan, the national plan for schizophrenia research, and the new NIMH program in mental disorders in children and adolescents.

To do this, Mr. Chairman, the Society for Neuroscience requests that the President's proposed fiscal year 1990 budget for NIMH of $487 million be increased by $150 million to a total of $637 million so that the momentum of neuroscience research into the cause, treatment, and prevention of mental illness can be sustained and enhanced.

While this amount will significantly impact on the support of research and research training in the brain sciences, it will also provide a greater impetus for research and clinical services in all aspects of mental health.

I think there is a critical threshold that must be reached to continue to support an effective research enterprise in mental illness. Congress can send no clearer signal to the people of this Nation that it cares about the mental health of its citizens than by supporting research aimed at eradicating mental illness and other cancers of the mind.

PREPARED STATEMENT

I want to thank you, Mr. Chairman, on behalf of the 14,000 members of the Society of Neuroscience. I have already heard from some of your statements your clear appreciation of the role of basic research into nerve functions as the fundamental way in which we are going to understand all these cancers of the mind, and I want to thank you for your support.

[The statement follows:]

STATEMENT OF DOMINICK P. PURPURA

Mr. Chairman, I am Dominick P. Purpura, M.D., Professor of Neuroscience and Dean of the Albert Einstein College of Medicine, Yeshiva University, New York. I come before this committee as a neuroscientist, Past-President of the Society for Neuroscience, currently President of the International Brain Research Organization which includes over 20,000 neuroscientists from 52 countries. I am a member of the National Academy of Sciences and the Institute of Medicine of the Academy. I am honored to be here representing the Society for Neuroscience and to enthusiastically endorse the professional judgment alternative budget appropriation request for the National Institute of Mental Health for $637M.

Mr. Chairman, mental illness in its various insidious forms is the single most costly disorder affecting the people of this great Nation. More than 25 million adults in the U.S. suffer from diagnosable mental disorders at any one time. Among children and adolescents 12 to 18 percent may be victims. Because mental illness is frequently shrouded in mystery and shame and stigmatizes those who suffer untold agonies, it is often hidden, ignored or trivialized than recognized and alleviated, only 20 percent of those with mental disorders receive treatment.

Reluctance to confront and conquer mental illness in our private lives has a parallel in our public policies. The mental health field has been severely underfunded relative to the national magnitude and cost of mental illness estimated at over $100 Billion. According to the Institute of Medicine, the personal and social costs of alcohol, drug and mental (ADM) disorders are comparable to those for heart disease or cancer -approximately $1000 per year for every man, woman and child in the U.S. But in FY 1988, the per capita Federal commitment to research on ADM disorders was only about $1.80. A lack of consistent, committed support for research has slowed the growth of the very knowledge and scientific manpower needed to conquer complex disorders of brain and behavior. This paucity in funding research related to mental disease has occurred at a time of unprecedented opportunities for neuroscience investigations into the basic mechanisms underlining normal and aberrant behavior.

Neuroscience research can cut the staggering costs of mental illness by moving us toward more effective and less expensive technologies. Some glimmers of decisive technology have already produced immense savings in the mental health field, thanks to an intensively developing base of scientific knowledge. The development and use of lithium as a treatment for manic-depressive illness, for example, saved the U.S. an estimated

$4 Billion during a 10-year period — $2.88 Billion in treatment costs and another $1.28 Billion in increased productivity. The discovery of carbamazepine as a therapy for lithium-resistant manic-depression is expected to save an additional $1 Billion to $4 Billion. Since people suffering from manic-depression are prone to suicide, use of lithium and carbamazepine unquestionably saves lives. An HHS-sponsored project estimated that the average life span of young adults suffering from manic-depression increases by 6 to 7 years when lithium treatment is combined with an education program. These treatments also improve the quality of life for patients and their families.

Similar advances are needed for a host of other costly, devastating, and still unconquered disorders. In the case of schizophrenia, for example, research advances that reduce by as little as 10 percent the number of episodes of illness, their duration, or their intensity would cut yearly treatment costs by $700 Million, to say nothing of the increased quality of patient's lives and productivity.

The NIMH supports and conducts a comprehensive program of basic and clinical research aimed at understanding and controlling the complex factors that underlie serious mental disorders. Recent NIMH initiatives to accelerate progress in combatting these disorders include:

° Implementing the first steps of the National Plan for Schizophrenia Research, a national research agenda issued by the National Advisory Mental Health Council in 1988;

° Capitalizing on the explosion of opportunities in neuroscience research articulated in the "Decade of the Brain" report;

° Developing a national research program to improve identification, treatment, and services for people with severe, persistent mental illness;

° Building and coordinating a coherent program of research on suicide across the life-span;

° Stimulating systematic research on AIDS, including a focus on central nervous system aspects of HIV infection and techniques of prevention.

Dramatic advances in mental health research are already evident in the following recent NIMH funded achievements:

° Identifiable and perhaps ultimately correctable genetic defects contribute to mental disorders. For example, linkages between schizophrenia and abnormalities on chromosome 5 have been disclosed in recent population genetic studies. Similarly, depressive disorders have been linked to both chromosomes 11 and the X chromosome and between Alzheimer's disease and chromosome 21. The ultimate aim of these genetic studies is to identify the gene products that are responsible for or contribute to these most debilitating disorders of the human condition. Once these products are know, safe and natural processes and therapies can be defined to diagnose, predict and prevent these disorders;

° Recent studies using magnetic resonance imaging (MRI) have disclosed distinct changes in the gross structure of the brain in schizophrenia and autism. Functional changes in the metabolic activity of the frontal lobes as compared with normals have been disclosed by other advances in imaging (SPECT);

° Pharmacological advances have permitted lithium carbonate, a drug long used in treating manic-depression illness, to be employed in diminishing - aggression and explosive behavior in children with conduct disorder;

° Discovery of a possible biological marker for Alzheimer's disease in blood platelets may greatly improve the reliability of diagnosis early in the course of this disease when pharmacological intervention may be effective;

° NIMH intramural scientists have explored the relationship between cocaine abuse and lethal convulsions and the potential therapeutic effects of the anticonvulsant drug carbamazepine in preventing the human death toll from cocaine.

To further advances in neuroscience and related research into mental disorders the Society for Neuroscience calls for selective increases in the President's proposed FY 1990 budget, which in effect represents a substantial short-term commitment and encouraging start for a number of the much needed initiatives such as the "Decade of the Brain" plan, the National Plan for Schizophrenia Research and the initiative on Mental Disorders in Children and Adolescents.

Mr. Chairman, the Society for Neuroscience requests that the President's proposed FY 1990 budget for NIMH of $487 Million be increased by $150 Million to a total of $637 Million. These additional funds will permit funding a variety of critical research and training programs such as the following:

° 450 new and competing research project grants;

° 50 research centers, 13 of which would be newly established and dedicated to such topics as suicide, child disorders, neuroscience of serious mental disorders, molecular biology, brain imaging and services financing;

° 274 research career grants, including 80 new awards;

° 2000 research trainees supported through individual and institutional awards to assure a continuing supply of superb basic and clinical investigators in the mental health field;

° 46 research and development contracts to stimulate the systematic growths of knowledge and technical expertise in key targeted areas including genetics research;

° 610 full-time equivalent staff within the NIMH Intramural Research Program to sustain its world leadership in basic and clinical mental health research.

The Society for Neuroscience champions the view that the augmented FY 1990 budget of $637 Million will facilitate the transformation of today's promises into tomorrow's realities.

° We will understand the factors that place children at risk for depression, severe anxiety disorders, antisocial behavior and substance abuse;

° We will define potential biological markers for mental disorders including Alzheimer's disease, schizophrenia and depression;

° We will provide a clearer picture of how interneuronal communication occurs under normal and abnormal conditions. This will lead to a powerful augmentation in psychotherapeutic agents;

° We will understand how the nervous system interacts with the immune system in health and disease;

° We will explore the feasibility of applying the growing array of medical and surgical techniques - including "transplants" (grafts) — to find ways to replace cortical neurotransmitter and neuromodulator chemicals in the brain;

° We will comprehend the basic mechanisms in eating disorders; the role of disturbed biological rhythms in mental illnesses and expand the opportunities for specific behavioral therapies for relapse prevention in treating addictive disorders.

In sum, the most complex behavioral process of the human brain reflect the operations of fundamental neuronal mechanisms. Neuroscience research aims to comprehend these mechanisms. It thus constitutes the driving force for a scientific approach to understanding mental illness and eventually, the treatment and prevention of aberrant human behavior, and the suffering and economic burden this entails.

Senator ADAMS. Thank you, Doctor. Have you requested any amounts from the new so-called drug czar, Mr. Bennett, for this type of program? If not, I would suggest to those of you who are dealing with this—and I would like to have you state for me because you can do it more clearly than I can, Doctor, the relationship between the effect of what a drug such as cocaine or crack will do in terms of increasing the flow of neurons into the brain, into the receptors. Would you describe that just briefly and then indicate how little or how much we know about it?

Dr. PURPURA. Well, we are fully aware now that there are very specific parts of the brain that seem to be targeted by these particular addictive drugs, and those parts of the brain have very phylogenetically old relationships to emotional activities.

These drugs overstimulate those regions of the brain, and now there is evidence that the overstimulation also produces virtually seizure-like, epileptic-like, activities in those selected deep parts of the brain. It is remarkable that even some of the drugs which over the years have been effective in the management of epilepsy which are now surprisingly able to combat some of the epileptic-like activities in regional parts of the brain that are responsible for the extraordinary burst of emotional energy and the bizarre behavior, almost uncontrollable.

But those are arising. Those bizarre behaviors are due to activities in very selected parts of the brain which can be controlled once we understand more the pharmacology and the receptor systems that are so regionally localized. That's where the hope lies. I think that molecular pharmacology today will be able to provide such agents to combat—while we deal with the sociological problems, while we combat the medical neurobiological problem.

Senator ADAMS. I am not downgrading the sociological problems, but I would be very supportive of any of your efforts to obtain funds because funds are going to be difficult to obtain in all areas, as we all know, that are directed toward that particular problem because I think it is one that we know very little about, and I think there is a direct connection between the use of many of these new substances that are producing not only violent behavior but suicidal behavior and so on in the neurological arena.

Dr. PURPURA. That's a very perceptive comment. Thank you very much.

Senator ADAMS. I appreciate very much your testimony.

Our next witness is Dr. David Johnson, Federation of Behavioral, Psychological, and Cognitive Sciences. A pleasure to have you with us, Dr. Johnson, and we look forward to hearing your testimony.

STATEMENT OF DAVID JOHNSON, PH.D., EXECUTIVE DIRECTOR, FEDERATION OF BEHAVIORAL, PSYCHOLOGICAL, AND COGNITIVE SCIENCES

Dr. JOHNSON. I ask that my full testimony be entered into the record, and I'll summarize.

Senator ADAMS. All right. Without objection, the entire testimony will appear in the record as though given, and we are glad to hear your testimony.

Dr. JOHNSON. Mr. Chairman, I represent behavioral researchers supported by the Department of Education, the National Institutes of Health, and the Alcohol, Drug Abuse, and Mental Health Administration. So, I will comment briefly on each appropriation.

One needs knowledge to solve problems. Research generates knowledge. Yet, educational research is among the least well supported means to improve educational quality. It is time to strengthen the Office of Educational Research and Improvement and field initiated research needs attention first. We support both the President's $13 million initiative called expanding experiments for educational achievement and the requested $1 million for field initiated research, but we recommended the President's initiative be made part of the field initiated program bringing the appropriation to $14 million for fiscal year 1990.

At NIH, the National Institute on Child Health and Human Development is a concern. Created with less funding than most institutes, it also tends to receive smaller increases. The result is a declining proposal to grant ratio. In 1987, it funded 35 of every 100 worthy proposals. The President's request would reduce the ratio to 19.7 per 100, a ratio sustainable only with negotiated reductions of 10.2, 14.2, and 17.5 percent for new, noncompeting, and center grants.

When NICHD was created, infant mortality was 25.3 per 1,000 live births. It is now 10.4. Without renewed support, that success will not be repeated.

In particular, we ask that an additional $2.5 million be appropriated to implement the most comprehensive study to date of the effects of nonparental child care on children from birth to 42 months of age. A funding shortfall threatens to reduce the scope of that project by 40 percent.

Animal research concerns both NIH and ADAMHA. Many scientists cannot continue their work because of increased costs from animal welfare regulations. A study of publication patterns in four scientific journals that publish animal research shows that in the past 10 years the number of articles published decreased 17 percent. U.S. scientists accounted for that decline. Articles by U.S. scientists declined 22.8 percent. Articles by non-U.S. scientists increased by 26.6 percent.

PREPARED STATEMENT

We make three recommendations. Funding must be provided to put enough knowledgeable inspectors in the field to monitor compliance. Sufficient funds must be provided in research grants to make compliance possible. Finally, we ask for some regulatory relief. We believe that current regulations assure humane animal care in laboratories.

Thank you for this opportunity to testify.

[The statement follows:]

STATEMENT OF DAVID JOHNSON

Mr. Chairman, members of the Subcommittee, my name is David Johnson. I am Executive Director of the Federation of Behavioral, Psychological and Cognitive Sciences, an organization of 15 scientific societies and 125 university departments and research centers. The Federation represents more than 20,000 scientists whose work is supported by the Department of Education, the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. I will comment on the appropriation for each agency.

DEPARTMENT OF EDUCATION

While the nation needs better educated workers, international comparisons show our students perform poorly across many subject areas. It would be wonderful if the problem had one solution. But it is complex, requiring attention at many points. One must have knowledge to solve a complex problem. The role of research is to create knowledge. So it is surprising that research is among the least well supported approaches to improving general education. State and local governments control many aspects of education, but not research support. Federal support has been mired in controversy and has suffered as a result. The power to enable researchers to participate effectively in solving our educational problems resides in a significant degree with this committee.

The Office of Educational Research and Improvement and the National Center for Education Statistics are the two federal offices concerned with research to improve general education. NCES's statistics show whether measures to improve education are having an impact. OERI funds research to tell us what measures can improve education as well as what current practices might be retarding educational progress. Congress has recently strengthened NCES. The office has received its own Commissioner, greater autonomy and sufficient funds to function at a high standard of quality. It is time to strengthen the Office of Educational Research and Improvement. OERI funds educational research in three major ways. It supports subject-specific research centers, regional labs that assist in the application of research to local needs, and it funds a field initiated research program. Each is necessary to a full research program. But the components do not receive equal funding attention. The field initiated program is 1/35th the size of either the centers or the labs program.

Each component serves a function equal in importance to the others. Funding should reflect that co-equality. The centers program concentrates research on specific topic areas facilitating maturation of a body of research. The labs facilitate successful local application of research. The field-initiated research program should be the wellspring of innovative research ideas and approaches, but it does not fulfil its potential. This wellspring of fresh ideas for the improvement of all general education is funded at $500,000. That is not a wellspring. It is a dry hole. IN FY90, it will fund 8 of 216 proposals submitted. For FY90, the Administration requests $1 million. We urge the Subcommittee to approve at least that amount, and to consider increases to make the field initiated program equal to the other two components. We support the President's request for $13 million to begin the Expanding Experiments for Educational Achievement initiative, but ask the Subcommittee to add this request to the field-initiated program. A $14 million appropriation would begin to put the program on a par with the centers and labs. We suggest these funds be accompanied by strong report language guaranteeing peer review of applications by qualified scientists and educators.

NATIONAL INSTITUTES OF HEALTH

Turning to the NIH, I want to mention an important initiative whose full usefulness is in jeopardy. Fifty-two percent of mothers with children under the age of two work outside the home. Two-thirds of these hold full-time jobs. About 40% of the U.S. population is in its child bearing years. We need to know what constitutes non-parental, quality child care because millions of below-school-age children spend more waking hours with alternative care providers than with mothers or fathers. The purpose of the NICHD initiative is to determine how this fundamental change in child rearing is affecting children. Ten investigators were chosen to head research teams. Each team is to examine unique research questions as well as major questions that will be examined in common. Now it appears four teams will be eliminated because of a funding shortfall. A project of this magnitude is unlikely to be attempted again. The job must be done right this time. All ten principal investigators are being included in the research design planning and coordination phase of the project. But unless additional funds are forthcoming, nearly half the project will never be carried out. We ask the Subcommittee to provide an additional $2.5 million to NICHD to fully fund this initiative.

NICHD, one of the few Institutes whose mission is not disease specific, is charged with understanding normal growth and development and using that understanding to overcome disorders in development as well as problems associated with population and environmental change. Created with a smaller funding base than many of the Institutes, it tends to receive lesser increases. The cumulative impact is of concern. A measure of a research institute's health is its grant-to-proposal ratio. NICHD has a lower ratio than most Institutes, and it is falling. In 1987, it funded slightly more than 35 of every 100 proposals judged scientifically sound and worthy of support. In 1988, that ratio fell to 27 per 100. Now it is slightly more than 25 per 100. The FY90 request would reduce the ratio to less than 20 per 100. Funding for each proposal is also dropping. At the requested level, downward negotiations of 10.2%, 14.2% and 17.5% will be necessary for competing, and noncompeting proposals and centers, respectively. There is a point at which such cuts no longer excise fat but are cutting away muscle. We receive reports from our researchers about the measures they take to meet the cuts. Graduate student assistants are cut first. Money they relied on to support their education is suddenly unavailable. Research experience vital to their training is lost. Next, the scope of research is reduced. Less research is done. Principal investigators find themselves devoting a greater proportion of their time to proposal writing to make up the shortfall. In the case of centers, maintenance is delayed. Research suffers as equipment falls into disrepair.

It is said that the deficit mortgages our children's future. Retarding research on child health and human development also mortgages our children's future. In the case of the budget, we are spending our children's money. In the case of research cuts, we are foregoing discoveries and applications that could have improved their health and development and could have saved some of their lives. When NICHD was created in 1961, the infant mortality rate was 25.3 per 1000 live births. Now it is 10.4. That dramatic change did not happen by luck. It happened because research led to improved prenatal and neonatal care practices. We ask that the Subcommittee do all in its power to restore to NICHD the research strength that will allow it to continue to improve the health and save the lives of our children.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

I want to discuss a matter affecting both NIH and the Alcohol, Drug Abuse and Mental Health Administration: the escalating cost of research employing animals. Many researchers are questioning whether they can afford to continue their work. The increased costs are felt in an array of research areas. Heart surgeon pioneer Michael DeBakey's research center complies with the latest standards for animal care. It cost several million dollars to meet those requirements, much of it raised from private sources not practically available to those lacking DeBakey's fame. Few other heart disease research labs will be able to raise the funds to meet ever more expensive requirements. The effect will be that fewer people will survive heart disease.

On the behavioral side of research, work on voluntary and involuntary processes in learning, on the toxicological effects of drugs and alcohol, on cures for addiction, and on the relationship between neural structure and behavior have been affected by rising animal care costs. A recent ten year survey of four major journals publishing research using animals shows the number of articles published decreased by 17%, and the number of experiments reported decreased by 18%. U.S. scientists accounted for the whole of the decline. The number of articles published by U.S. scientists declined 22.8% while the number of articles by non-U.S. scientists increased by 26.6%. How much have costs escalated? One researcher reported to us that the cost to maintain his research animals had increased 270% in the past four years. In 1986 it cost 7 cents per animal per day. In 1989 it cost 26 cents per animal per day. The impact of increased regulation is clear. U.S. scientists in a host of specialties are losing preeminence to researchers in other countries. We have three recommendations. Funding must be provided to put enough trained, knowledgable inspectors in the field to monitor compliance. Sufficient funds must be provided in research grants to make compliance a realistic possibility. Finally, we ask the Congress for regulatory relief. Current regulations assure humane animal care and treatment in laboratories. If there were no government regulations most researchers would take extremely good care of their animals because it is in the best interest of research to do so. Unhealthy animals compromise research outcomes, and deaths in the animal colony can invalidate experiments altogether. Moreover, the cost of decontaminating facilities and of replacing lost animals is prohibitively expensive. More regulation will not measurably improve conditions for animals but will inhibit science and will place additional burdens on limited federal research funds.

The Alcohol, Drug Abuse and Mental Health Administration has always been a distant second to NIH in funding, yet the toll from drug and alcohol abuse and mental disorders is comparable to that of the diseases on which NIH focuses resources. A 1984 Institute of Medicine study estimated direct annual health costs related to alcohol, drug and mental problems at $20 billion and total cost to the economy at $185 billion. 15% of the U.S. population suffers from a mental disorder or from drug or alcohol abuse. The return to the economy for relatively small investments in research has the potential to be enormous. The President's request for ADAMHA will not maintain current services, and the President proposes to include ADAMHA in his flexible freeze. We urge that ADAMHA, like NIH, not be part of a flexible freeze. We also recommend that the Congress approve an appropriation for ADAMHA that would allow it to maintain current services. Finally, we urge that separate funds be appropriated to continue administration of AZT to AIDS patients and that this money not be taken out of research funds. Thank you for this opportunity to present our views.

Senator ADAMS. Thank you very much, Dr. Johnson.

Where have you taught?

Dr. JOHNSON. At Stanford and San Jose State University in California.

Senator ADAMS. Thank you. I was interested. Your testimony sounds very similar to testimony that I have heard from those doing work in this field at Hampshire College where I was a trustee for a while. And I was fascinated by the similarities.

Dr. JOHNSON. We probably have similar points of view.

Senator ADAMS. You do, and I am pleased to hear them. We appreciated very much hearing your testimony this morning.

Dr. JOHNSON. Thank you.

STATEMENT OF ITAMAR B. ABRASS, M.D., PROFESSOR OF MEDICINE, HEAD, DIVISION OF GERONTOLOGY AND GERIATRIC MEDICINE, UNIVERSITY OF WASHINGTON

Senator ADAMS. Our next witness is Dr. Itamar Abrass, Department of Geriatrics, the University of Washington School of Medicine. Doctor, welcome. We're glad that you are here. It's raining in Seattle. It's raining here. [Laughter.]

So, we are both comfortable.

Dr. ABRASS. Thank you very much. I request that my statement as submitted and as I read here be entered in full.

Senator ADAMS. All right. Without objection, your entire statement will be entered in full as part of the record.

Dr. ABRASS. Besides Alzheimer's disease, maintenance of effective functioning of older adults, and long-term care, the development of leadership in geriatric medicine is a major challenge to gerontology in the United States. The 1987 Institute of Medicine report entitled "Academic Geriatrics for the Year 2000" recommended centers of excellence as the best way of developing the needed faculty and leaders.

In 1984, the 12 percent of our population over age 65 accounted for over 33 percent of physician time use, 25 percent of medication costs, and 40 percent of acute hospital admissions. As people live longer and are better educated, their demand for medical services will increase. The most rapidly growing portion of our population is a group over the age of 85. It is estimated that the number of people over 85 will double by the year 2000 and will increase five-fold by 2050. Thus, the impact of an older population on the health care system is clear.

The health care needs of the aging population require a combination of medical care approaches that are different from those for younger patients. Every primary care physician needs to be knowledgeable about the normal changes accompanying aging and the unique aspects of diseases common in older people. It will not be long before every physician's practice, except for obstetrics and pediatrics, will be mostly geriatrics.

Although current estimates of the availability of geriatricians vary, several studies are unanimous in demonstrating a lack in the needed faculty, scientists, administrators, and clinicians. The Institute of Medicine report estimated a total need of 2,100 physician faculty and 8,000 geriatric clinical specialists by the year 2000. Although these numbers probably underestimate future manpower needs, they outstrip current productivity. Internal medicine, family practice, and psychiatry have recently developed criteria for added qualifications in geriatric medicine, and medical schools plan enhanced geriatric curricula. Thus, the urgent need for qualified faculty has been intensified.

How to best meet this challenge? Geriatrics is emerging nationally during times of constrained financial resources and limited numbers of qualified faculty. These scant resources must be focused to yield a maximum training of the next generation of academic leaders. It was the consensus of the Institute of Medicine report that program development and training can best occur in centers of excellence which have sufficient support staff and a critical mass of faculty and other professionals. Such centers would emphasize the training of physician faculty, geriatricians in an environment of model teachers, varied basic and clinical research, and diverse clinical opportunities. Such centers could protect trainees from the demands of academia allowing them time to mature and become established investigators. As the number of faculty trained in these centers increases and they return to academia, many medical schools eventually will be able to develop quality programs to train more faculty as well as geriatric specialists and primary care physicians with geriatric expertise.

The Omnibus Health Programs Extension Act of 1988 specifically authorizes the National Institute on Aging to support centers of geriatric research and training. NIA has requested applications for such centers and currently has nine applications from outstanding institutions in review. However, in fiscal year 1989, the NIA's budget will only allow for the funding of one such center. This is certainly inadequate to meet the stated need.

The average cost per geriatric research and training center would be approximately $1.2 million, a modest amount relative to the benefits for health care and research progress that would result.

PREPARED STATEMENT

I urge this committee to support the expansion of the fiscal year 1990 National Institute on Aging budget to include designated funding for 5 to 10 geriatric research and training centers. I also urge this committee to support enhancement of the NIA budget to assure adequate support of career development and research opportunities. Without such support, we will fail to attract our best scientists and clinicians to geriatric medicine.

Thank you.

[The statement follows:]

STATEMENT OF ITAMAR B. ABRASS

Besides Alzheimer's Disease, maintenance of effective functioning of older adults, and long-term care, the development of leadership in geriatric medicine is a major challenge for gerontology in the United States. The 1987 Institute of Medicine report entitled "Academic Geriatrics for the Year 2000" (published in J Amer Geriatr Soc 35:773-791, 1987) recommended centers of excellence as the best way of developing the needed faculty and leaders.

In 1984, the 12% of our population over age 65 accounted for over 33% of physician time use, 25% of medication costs, and 40% of acute hospital admissions. As people live longer and are better educated, their demand for medical services will increase. The most rapidly growing portion of our population is the group over the age 85. It is estimated that the number of people over 85 will double by the year 2000 and will increase five-fold by 2050. Thus, the impact of an older population on the health care system is clear.

The health care needs of the aging population require a combination of medical care approaches that are different from those for younger patients. Every primary care physician needs to be knowledgeable about the normal changes accompanying aging and the unique aspects of diseases common in older people. It will not be long before every physician's practice, except for obstetrics and pediatrics, will be mostly geriatrics.

Although current estimates of the availability of geriatricians vary, several studies are unanimous in demonstrating a lack in the needed faculty, scientists, administrators and clinicians. The Institute of Medicine report estimated a total need of 2,100 physician faculty and 8,000 geriatric clinical specialists by the year 2000. Although these numbers probably underestimate future manpower needs, they outstrip current productivity. Internal Medicine, Family Practice, and Psychiatry have recently developed criteria for added qualifications in geriatric medicine, and medical schools plan enhanced geriatric curricula. Thus, the urgent need for qualified faculty has been intensified. .

How to best meet this challenge? Geriatrics is emerging nationally during times of constrained financial resources and limited numbers of qualified faculty. These scant resources must be focused to yield maximum training of the next generation of academic leaders. It was the consensus of the Institute of Medicine report that program development and training can best occur in "centers of excellence," which have sufficient support staff and a critical mass of faculty and other professionals. Such centers would emphasize the training of physician faculty geriatricians in an environment of model teachers, varied basic and clinical research, and diverse clinical opportunities. Such centers could protect trainees from the demands of academia, allowing them time to mature and become established investigators. As the number of faculty trained in these centers increases and they return to academia, many medical schools eventually will be able to develop quality programs to train more faculty as well as geriatric specialists and primary care physicians with geriatric expertise.

Geriatrics can benefit from the history of other academic programs, especially oncology. The field of oncology was not particularly attractive until the federal government spurred interest in all research related to cancer. A national commitment guaranteed stable and adequate financial support through the National Cancer Institute and special programs such as Cancer Centers. Probably because of this funding, oncology developed a quality academic identity on the basis of both clinical and biomedical research. That experience provides a valuable model for the development of geriatrics. There is a need for the establishment of geriatric centers of excellence and for assurance of adequate financial support for career development and on-going research.

The Omnibus Health Programs Extension Act of 1988 specifically authorizes the National Institute on Aging to support Centers of Geriatric Research and Training. NIA has requested applications for such Centers and currently has nine applications from outstanding institutions in review. However, in FY 1989 the NIA's budget will only allow for the funding of one such Center. This is certainly inadequate to meet the stated need.

The average cost per Geriatric Research and Training Center would be approximately $1.2 million, a modest amount relative to the benefits for health care and research progress that would result.

I urge this Committee to support the expansion of the FY 1990 National Institute on Aging budget to include designated funding for 5-10 Geriatric Research and Training Centers. I also urge this Committee to support enhancement of the NIA budget to assure adequate support of career development and research opportunities. Without such support, we will fail to attract our best scientists and clinicians to geriatric medicine.

Mr. Chairman and Committee members, I thank you for giving me this opportunity to address you.

I will be happy to answer any questions.

Senator ADAMS. Thank you very much, Doctor. My family, in particular my wife's mother, went through 12 years of Alzheimer's disease with no hope and no way of treatment, and we spent a lot of time with the elderly population. So, I am certainly hopeful that we will be able to do something with this and have more than one center.

Dr. ABRASS. Thank you. I appreciate your support.

Senator ADAMS. We're glad that you were here.

It gives me a great deal of pleasure to introduce Senator Specter from Pennsylvania. If you would like to call your witness now, and then in a few moments, I think we will have to recess for a moment.

STATEMENT OF DAVID KUPFER, M.D., AMERICAN PSYCHIATRIC ASSOCIATION

Senator ADAMS. At this point we would like to call back Dr. David Kupfer, and Senator Specter will introduce and question Dr. Kupfer. Welcome. We are pleased that you are here and I know Senator Specter has some comments he may wish to make about you, Doctor.

Senator SPECTER. Well, Dr. Kupfer is a distinguished professional representing here today the American Psychiatric Association from the University of Pittsburgh, a long-standing friend of mine. We have worked together on many matters in the past, and I appreciate your having deferred, Dr. Kupfer, to a time when I could be here.

Before Dr. Kupfer starts his testimony, I would like to acknowledge the presence of Dr. Robert Perloff who is a professor of business administration and psychology from the University of Pittsburgh, and he has already testified on behalf of the American Psychological Association. So, I regret that I could not be here earlier. We have many prominent Pennsylvanians in this important field.

So, welcome, Dr. David Kupfer, and you may proceed.

Dr. KUPFER. Thank you, Senator.

Mr. Chairman, I ask that my full testimony be accepted for the record, and I will only highlight.

Senator ADAMS. Without objection, your full testimony will appear as though given in the record at this point, and we welcome your testimony.

Dr. KUPFER. Thank you.

Research on the treatment of mental and addictive disorders has moved far enough along that we are in a position to treat these disorders today. We do not need to present promissory notes to the Congress.

The implementation of plans that have already been initiated and supported by Congress represents our best shot at reducing the pain, suffering, and enormous economic costs of our serious mental disorders.

For example, within any 6-month period, one out of five adult Americans will suffer from a diagnosable mental disorder; 12 million children and adolescents experience mental disorders.

At any time more than 100,000 hospital beds are occupied by persons with schizophrenia.

By the year 2,000, 2.4 million Americans will be suffering from Alzheimer's disease.

Alcohol abuse is a factor in nearly one-half of all accidental deaths, suicides, and homicides in the United States.

As you know, a dramatic revolution is underway, Mr. Chairman, in the science of understanding and treating mental disorders and the interrelated illnesses of alcoholism and drug abuse.

Simultaneously, and equally important, public understanding of the complex nature of the mental and addictive disorders has evolved and heightened slowly serving to eradicate the dangerous social stigma attached to these disorders which often prevents individuals from seeking necessary and appropriate treatment.

I'm sure you have probably seen the U.S. News & World Report of April 24. There was an article called "When Mental Illness Hits Home." I think one of the poignant things in this particular article was a mother saying "I swear to God I would rather my child had cancer than the agony of the disease of schizophrenia."

The clinically inspired basic research treatment and prevention studies supported by NIMH are yielding promising results. With growing evidence of strong biological components in the origins of many of these severe disorders, new avenues for progress appear to be present.

Particularly exciting is the molecular research, some of which you have already heard this morning, being conducted by each of the ADAMHA institutes that suggest that these disorders are genetically based. This is important because it provides the key to the development of more specific interventions.

The public expects and demands the ADAMHA to both expand knowledge and expand the Nation's services outreach capacity. For example, nearly 500,000 citizens have petitioned Congress to invest $500 million for NIMH research. Congressman Silvio Conte's decade of the brain plan for the neurosciences and Senator Pete Domenici's national plan for research on schizophrenia are two important linkages to the future of mental health care delivery. So, too, will be the upcoming recommendations from the Institute of Medicine on a national initiative to expand research on child and adolescent disorders.

PREPARED STATEMENT

In order to carry out this agenda, which includes your support for a $500 million NIMH research budget, we will need this commitment for resources and for training, particularly the research training of young investigators. We are at a crucial period of time. It is important to realize that this critical period may mean that if the resources are not brought to bear on these serious problems today, the development over the past several years that you have engineered and have been responsible for will not simply be delayed. Many of us believe it will be disrupted.

I hope that you will agree with us that we cannot only overcome these mental and addictive disorders, but we can do so today. We should not wait any longer.

[The statement follows:]

STATEMENT OF DAVID KUPFER

Mr. Chairman and Members of the Subcommittee, I am Dr. David Kupfer, Professor and Chairman of the Department of Psychiatry at the University of Pittsburgh. I appear before you today on behalf of the American Psychiatric Association, a medical specialty society representing more than 35,000 psychiatrists nationwide; the American Association of Chairmen of Departments of Psychiatry; the American Association of Directors of Psychiatry Residency Training Programs; and the American Society of Adolescent Psychiatry. I also wish to associate the APA with the testimony of the Ad Hoc Group for Medical Research Funding and the Coalition for Health Funding.

Due to the shortness of time, I will devote the majority of my testimony to the research budgets for mental and addictive disorders. The urgent need for the research investment is seen in the grim data:

* Within any six-month period, one out of five adult Americans suffers from a diagnosable mental disorder or an alcohol or drug disorder.

* Twelve million children and adolescents experience mental disorders. The fetal alcohol syndrome occurs in 10 to 30 babies per 10,000 live births.

* More than 2 million Americans will be stricken with schizophrenia over the course of their lifetimes and at any one time more than 100,000 beds are occupied by persons with schizophrenia.

* By the year 2000, 2.4 million Americans will suffer from Alzheimer's disease.

* Alcohol abuse is a factor in nearly half of all accidental deaths, suicides and homicides in the U.S.

* As many one-third of the homeless people in the country are mentally ill. Many more also have alcohol or other drug problems.

- Nearly one-third of all new cases of AIDS are occurring in intravenous drug users.

- By 1985, twelve percent of Americans had used cocaine, which is the leading cause of drug-related emergency room visits.

As you know, a dramatic revolution is underway, Mr. Chairman, in the science of understanding and treating mental disorders and the interrelated illnesses of alcoholism and drug abuse. We have seen steady advances in diagnosis, epidemiology and treatment. We have see the introduction of tricyclics and MAO inhibitors, also used in the treatment of depression; of neuroleptics for those suffering from psychoses; of clozapine for those unresponsive to other neuroleptics; and chlomipramine for obsessive-compulsive disorders. We have also seen the increasing use of dynamically oriented but time-limited psychotherapy, as well as new techniques of crisis intervention, multiple-family group treatment for families with schizophrenic relatives, new behavioral treatments, and documented proof of the effectiveness of psychotherapy in the treatment of depression. Our field can now offer a variety of treatments.

Simultaneously, and equally important, public understanding of the complex nature of the mental and addictive disorders; their underlying co-morbidities and interrelationships; and the challenges of tailoring appropriate treatment to the affected individual has evolved and heightened, slowly serving to eradicate the dangerous social stigma attached to these disorders which prevent individuals from seeking necessary and appropriate treatment. Research is the most potent tool we have for generating valid bases for hope that mental and addictive disorders are amenable to treatment and for destigmatizing these disorders. The clinically-inspired basic research and treatment and prevention studies supported by ADAMHA are yielding promising results in the face of this enormous challenge. With growing evidence of strong biological components in the origins of many of these severe disorders, new avenues for progress in conquering them appear to be present. Particularly exciting is research being conducted by each of the ADAMHA institutes that involves studies of fundamental processes which appear to be driven by genetic anomalies. These leads are promising given the implications of well-defined genetic markers for targeting prevention to vulnerable individuals. We are confident that with the necessary funding investment, the research supported by the three ADAMHA institutes will yield economic and human dividends far in excess of our recommended initial research expenditure.

The public expects and demands the ADAMHA to develop research-based interventions that both expand knowledge and expand the Nation's services outreach capacity. Congressman Silvio Conte's "Decade of the Brain" plan for the neurosciences and Senator Pete Domenici's National Plan for Research on Schizophrenia are two important linkages to the future of mental health care delivery. So, will be the upcoming report from the Institute of Medicine on specific program and policy recommendations for a national initiative to expand research on child and adolescent mental disorders and the ongoing NIMH research in the area of mental disorders in the elderly.

While the Budget Committees have not permitted this Subcommittee much more than a "hold the line" approach to the funding of domestic discretionary programs, you should know that these funding limitations will significantly reduce the current level of research in the field. The funding levels incorporated into the Budget Resolution also threaten to dissuade talented young potential investigators from pursuing careers in research, thereby slowing the quest for knowledge necessary in conquering the devastating human tragedies of mental illnesses and substance abuse. The scientific pool of senior researchers is not being sufficiently replenished with young researchers. Although there is a growing interest among young physicians in entering the field, the numbers remain alarmingly low. It is critical that the needs of tomorrow's researchers be addressed without delay through substantial increases in the ADAMHA research training budget.

The "flexible freeze" approach to these programs means that, for example, we fail to make the all-out commitment to cocaine treatment research. It would be a national tragedy to stop in its tracks the work undertaken by the National Institute on Drug Abuse over the past three years to improve our ability to treat drug abusers, with a special emphasis on development of new pharmaceuticals to aid in treatment. It would equally shortsighthed to abandon ongoing scientific studies towards the development of a vaccine against HIV infection and in the area of reducing and preventing behaviors which put people at risk. Necessarily put on hold would also be the fine work of the National Institute on Alcohol Abuse and Alcoholism in understanding the fundamental mechanisms involved in intoxification, tolerance and addiction which may pave the way for improved interventions.

We concur with our colleagues in the Ad Hoc Group for Medical Research Funding that "it is an unfortunate truth that the ravages of human disease and disability, in suffering, in loss of human potential and in the negative impact on the nation's economy, are not lessened by the magnitude of the budget deficit". The promise of research for reducing these human and economic costs, as well as for contributing positive benefits to the nation's international competitive position, makes support for biomedical and behavioral research a high priority investment in the nation's future. Your support for a $500 million NIMH research budget would bring this day closer.

Remember that the introduction of lithium for the treatment of manic depressive illness led to a $8 billion savings in reduced medical costs and increased productivity in the fifteen years following its discovery. In the past the problems posed by psychiatric disorders seemed insoluble, but this picture has changed. History shows us that when a serious attack by the medical and scientific communities is launched, even the most crippling disease can be brought to its knees. We are thrilled to report that more than 400,000 Americans have already signed petitions circulated by the National Alliance for the Mentally Ill urging Congress to appropriate $500 million for NIMH research.

Mr. Chairman, we are suggesting for your Committee's consideration an alternative consensus set of budget recommendations to better address and facilitate the attainment of ADAMHA's mission. A table summarizing these recommendations — endorsed by several large and diverse coalitions — is appended. The cornerstone of our budget recommendations is a call to Congress to appropriate $500 million for research on mental disorders; $196 million for research on drug abuse; and $155 million for research on problems of alcohol. These recommendations include support for the training of future research personnel and support for the administration and management of these programs.

The Agency mission is broad and, as such, contains many diverse, yet interwoven, programs. Briefly, we propose for your consideration a $26 million appropriation for NIMH Clinical Training to better ensure the placement of mental health personnel in shortage areas and in public facilities and to improve the quality of training—in a field of exploding new knowledge from research advances—provided to mental health specialists.

The Alcohol, Drug Abuse and Mental Health Block Grant which now also includes the Emergency Drug Treatment Block Grant and a new program to reduce the transmission of AIDS by user of illegal intravenous drugs — requires a doubling of the President's budget request to $1.6 billion. There can be no overriding reason for holding at the current appropriation this program which provides funds to the states to support alcohol, drug abuse and mental health prevention, treatment and rehabilitation services to those in dire need.

We request Congress to reauthorize and then appropriate $10 million for Comprehensive Planning Grants for Seriously Mentally Ill Persons to assist states in developed community care systems for the chronically mentally ill.

We support the Administration's request to fully fund the NIMH and NIDA/NIAAA homeless demonstration projects and seek your support for a $100 million appropriation to expand the state homeless grant program.

We recommend adequate increases to support these vital activities of the Office of Substance Abuse Prevention. We propose increases above the President's budget to permit ADAMHA to continue with important initiatives in AIDS research and to demonstrate the efficacy of delivering mental health treatment services for persons with HIV infection as authorized in last year's omnibus AIDS legislation.

Mr. Chairman, while acknowledging the need to address budget deficits in accordance with the Gramm-Rudman-Hollings Balanced Budget Act, we do not believe human services programs, including those of ADAMHA, should bear the burden of further cuts. These programs have already been pared to the bone, and Congress should look at alternate means to control the federal deficit.

Thank you again for this opportunity to appear before your Subcommittee.

ADAMHA

(dollars in millions)

	APPROP. FY '89	PRESIDENT FY '90	CURRENT SER. FY '90	OUR PROPOSAL FY '90
NIMH				
RESEARCH	293.5	306	333.1	404.9
RESEARCH TRAINING	19.7	20.3	20.5	43.6
RESEARCH MGT/SUPPORT	32.1	35.1	35.1	38.6
EXTRAMURAL CONSTRUCTION				15*
	345.3	361.4	388.7	502.1
DEMONSTRATIONS (CSP)	25.9	19	27.3	38.3
DEMONSTRATIONS (Homeless)	4.5	11.5	4.8	11.5
DEMONSTRATIONS (Prevention)	0	0	0	10
PROTECTION/ADVOCACY	12.8	10.5	13.3	22
CLINICAL TRAINING (ADAMHA)	12.8	8	13.3	29
NIDA				
RESEARCH	146.3	154.8	158.6	172.3
RESEARCH TRAINING	2.3	2.4	3	6
RESEARCH MGT/SUPPORT	15	16.4	16.4	18.4
	163.7	173.6	178.0	196.7
DEMONSTRATIONS	7	7	7.4	10
NIAAA				
RESEARCH	102.7	109.4	119.3	138.7
RESEARCH TRAINING	2.6	2.7	2.9	5.5
RESEARCH MGT/SUPPORT	9.2	10.3	10.3	11.6
	114.5	122.4	132.5	155.8
DEMONSTRATIONS(Homeless)	4.5	17	4.8	17
OSAP				
DEMONSTRATIONS	56.1	60.6	57.1	114.3
CLINICAL TRAINING	5	5.4	5.3	27.3
MGT/SUPPORT	8.7	10.9	9.8	12.7
	69.8	76.9	72.2	154.3
GRANTS TO STATES				
BLOCK (combined)	805.5	800	834.6	1600.0***
HOMELESS MENTALLY ILL	14.1	35	14.6	100
STATE MENTAL HEALTH PLANNING	4.7	0	4.9	10
AIDS				
NIMH				
Research	48.7	69.3	57.1	84.4
NIDA				
Research	28.2	57.3	125.4**	144**
Demonstrations	91.6	82.7		
NIAAA				
Research	6.1	8.3	5.1	9.6

* needs authorization
** combined research and demostrations.
*** includes supplemental funding

Senator **Adams**. Thank you very much, Doctor. Thank you for your testimony.

I will state to the other witnesses that we have a live quorum now in which we must be sworn, as I had indicated to all of the witnesses, for an impeachment proceeding which requires our presence on the floor. We will return and the committee will stand at recess subject to the call of the Chair.

Senator Specter has kindly consented to continue on with the hearing. So, he will be presiding and acting as chairman for a period of time. I will return as soon as I can, but I want to express my gratitude to him for continuing the hearing.

And particularly I want to express my appreciation to all of the witnesses who are here, as I said at the beginning of the hearing, not only for your appearing, but for your patience and for the wonderful cooperation you have given to the committee in presenting your testimony. It is very important to all of us, and we treat it with a great deal of seriousness. God willing, we will be able to do something for you.

So, the committee will stand at recess subject to the call of the Chair.

Senator **Specter**. May I just say something before we recess?

Senator **Adams**. Yes.

Senator **Specter**. I want to thank Dr. Kupfer for coming forward. He and I have talked about these and related problems. The absence of questions does not suggest our lack of keen interest. We have quite a number of witnesses to hear and there are a great many points we would like to ask questions about. We have discussed these matters before. So, I just wanted to make that comment.

Senator **Adams**. Thank you, Senator Specter, and that applies to all the witnesses. We had asked also that we may submit some questions in writing, and I have asked occasional questions as we have gone through. But this does not indicate a lack of interest. It indicates an attempt for everyone to have their say and we will follow with it.

Thank you, Doctor.

We stand in recess subject to call of the Chair.

[A brief recess was taken.]

STATEMENT OF ALAN DINSMORE, AMERICAN FOUNDATION FOR THE BLIND, INC.

Senator **Specter** [presiding]. We shall now resume the hearing of the Subcommittee on Labor, Health, Human Services and Education. We regret the delay because of the swearing-in of the Senate to serve as jurors in the impeachment proceeding for Judge Nixon, but you will all be glad to know that the business of the country is moving ahead.

We will now call Dr. Alan Dinsmore, American Foundation for the Blind. Welcome, Dr. Dinsmore. Your full statement will be made a part of the record, and you may proceed.

Mr. **Dinsmore**. Thank you, Senator.

My name is Alan Dinsmore, and I am with the Governmental Relations Department of the American Foundation for the Blind

[AFB]. AFB is a national voluntary research and professional organization in the field of blindness and visual impairment.

Let me say at the outset that we fully support the appropriations recommendations of the National Rehabilitation Coalition, the Consortium for Citizens with Disabilities, and the Coalition on Technology and Disability. Because of time and space limitations, our statement will highlight only those programs on which we believe we can provide a unique perspective.

First of all, turning to special education personnel development under part D of the Education of the Handicapped Act, we are recommending for fiscal year 1990 a $95 million funding level. This funding level should return the program to the level authorized prior to the authorization reductions of the Omnibus Reconciliation Act of 1981.

We are seriously concerned about the shortage of teachers who are trained to deal with the unique needs of blind and visually impaired children.

We are also concerned about funding levels for rehabilitation services and specifically in the instance of this statement, independent living services for older blind individuals under title VII, part C of the Rehabilitation Act. Here we are recommending a funding level of $6.3 million.

By the year 2000, the number of people over age 75 will increase by 56 percent. Persons who become blind at a young age can be expected for the most part to share in this longevity. Also, blindness or visual impairment is often associated with the aging process.

For media and captioned films—this is section 653 of the Education of the Handicapped Act—we are recommending a funding level of $15.9 million. We recommend this increase in the appropriation for media and captioned films. Our recommendation would permit a first-time funding of $1.3 million for video description services. Video description provides to blind persons a narration of the visual information presented on a television screen.

In addition, we recommend an increase in funding for Recording for the Blind, Inc., to $2 million in order that Recording for the Blind [RFB] would be able to meet the ever-increasing need for recorded textbooks for the blind and other print handicapped students at all education levels.

PREPARED STATEMENT

And, finally, under special institutions, the American Printing House for the Blind, we are recommending a funding level of $5.9 million. We recommend this increase for the American Printing House over last year's funding level as the number of students to be served continues to grow even though appropriations for the printing house have remained fairly constant over the past 10 years. In addition to braille and talking book production, the American Printing House for the Blind develops unique educational products which benefit blind children.

We appreciate this opportunity to provide our statement. We look forward to working for the committee on these funding levels.

Senator **Specter**. Thank you very much, Mr. Dinsmore. Thank you for staying within the allotted time. You present very important issues, and we shall consider them very carefully. Thank you.

[The statement follows:]

STATEMENT OF ALAN DINSMORE

My name is Alan Dinsmore of the Governmental Relations Dept. The American Foundation for the Blind is a national voluntary research and professional organization in the field of blindness and visual impairment. Let me say at the outset that we fully support the appropriations recommendations of the National Rehabilitation Coalition, the Consortium for Citizens with Disabilities, and the Coalition on Technology and Disability . Because of time and space limitations our statement will highlight only those programs on which we believe we can provide a unique perspective.

(All dollar figures are in millions)

Special Education Personnel Development

FY1988 Appropriation	FY1989 Appropriation	FY1990 Authorization	President's FY1990 Request	AFB FY1990 Recommendation
66.75	67.1	pending	flexible freeze	95. 0

This funding level would return this program to the level authorized prior to the authorization reductions of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). We are seriously concerned about the shortage of teachers who are trained to deal with the unique needs of blind and visually-impaired children. Congress needs to fund these programs at the recommended level to insure an adequate supply of qualified personnel who can instruct blind children in such skills as orientation and mobility and the use of braille.

Special Education Technology

FY1988 Appropriation	FY1989 Appropriation	FY1990 Authorization	President's FY1990 Request	AFB FY1990 Recommendation
4.69	4.73	11.025	flexible freeze	11.025

Access to adaptive technology, such as talking computer terminals, has a significant impact on appropriate education for children who are blind or visually-impaired. Accordingly, Congress should fund part G as recommended to assist in the development and availability of new technologies.

State Operated Programs (P.L. 89-313)

FY1988 Appropriation	FY1989 Appropriation	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
151.26	148.2	formula	flexible freeze	170.0

AFB believes that state-operated and state-supported schools for blind children are an important part of the continuum of placement options for blind and visually-impaired children, especially those who are multi-handicapped.

Rehabilitation Services--Independent Living Services for Older Blind Individuals - Title VII, Part C

FY1988 Appropriation	FY1989 Appropriation	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
5.6	5.7	6.3	flexible freeze	6.3

By the year 2000, the number of people over age 75 will increase by 56 percent. Persons who become blind at a young age can be expected, for the most part, to share in this longevity. Also, blindness or visual impairment is often associated with the aging process. The fully authorized amount of $6.3 million is, in fact, inadequate to meet the growing needs of this population. An effort will be made to reauthorize this program as a formula grant with a substantial increase in authorized funds when the Rehabilitation Act is next reauthorized.

Technology-Related Assistance Grants

FY1988 Appropriation	FY1989 Appropriation	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
Grants to States 0 Nat'l Programs 0	Grants to States 5.2 Nat'l Programs 0	Grants to States and Nat'l Programs such sums	Grants to States and Nat'l Programs flexible freeze	Grants to States 20.0 National Programs 6.5

(National Programs--Title II)

The Technology-Related Assistance for Individuals with Disabilities Act (P.O. 100-407) is a new discretionary program created to increase access to assistive technology devices and services for individuals of all ages and disabilities.

AFB strongly believes that the full participation of all states is needed to insure the development of comprehensive and coordinated systems of delivery for assistive devices and related services. In addition, funding for Title II activities, such as the authorized study by the National Council on Disability concerning financial and other barriers to the acquisition of needed technologies, is necessary particularly since technology is an important component of the effective education, rehabilitation, and productive life of blind and visually-impaired people.

Media and Captioned Films

FY1988 Appropriations	FY1989 Appropriations	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
13.2	13.4	pending	13.4	15.9

AFB recommends an increase in the appropriation for the media and captioned films account (Section 653 of the EHA). Our recommendation would permit first-time funding ($1.3 million) for video description services. Video description provides to blind persons a narration of the visual information presented on a television screen. In addition, we recommend an increase for the Recording for the Blind, Inc. to $2 million in order for RFB to meet the ever-increasing demand for recorded textbooks for blind or other print-handicapped students at all educational levels.

Special Institutions--American Printing House for the Blind

FY1988 appropriations	FY1989 appropriations	FY1990 authorization	FY1990 Presidents Request	AFB Recommendation
$5.266	5.345	such sums	5.345	5.941

We recommend an increase for the American Printing House for the Blind over last year's funding level inasmuch as the number of students to be served continues to grow even though the appropriation for the Printing House has remained fairly constant over the past ten years. In addition to braille and talking book production, APH develops unique educational products which benefit blind children.

Senior Community Service Employment Program (Title V)

FY1988 Appropriations	FY1989 Appropriations	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
336.0	343.8	426.2	336.0	426.0

We recommend full funding be provided so that minority participation can be increased and to assure the establishment of American Indians and Native Hawaiians contract programs. Minority groups statistically have a high rate of disability.

Research and Demonstrations (Title IV)

FY1988 Appropriations	FY1989 Appropriations	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
25.0	24.2	36.3	24.2	30.0

There is a great need for further research in minority participation in Older Americans programs. Data indicate that elderly minority participation rates in Older American Act programs have generally declined since 1980. There is a need for additional funding to determine why all minority groups do not access Older Americans Act programs. We are concerned that since there is a high incidence of blindness among minority populations, that many do not have an opportunity to participate or may in some way be discouraged from participation. The current funding of $24 million should be increased to at least $30 million.

Outreach to SSI, Medicaid and Food Stamp Recipients

FY1988 Appropriations	FY1989 Appropriations	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
-0-	-0-	10.0	-0-	10.0

In 1987, Congress enacted amendments which authorized $10 million in each of 1989 and 1990 and "such sums" in 1991 to expand outreach efforts to older poor persons who may be eligible for, but are not receiving, Supplemental Security Income (SSI), Medicaid and Food Stamps. This program was not funded in FY 1989.

Indications are that only about half those who could be eligible for SSI actually participate, with similar rates for medicaid and food stamps. Based on estimates, over 2 million elderly are not participating. The estimates of non-participation may well be low because those who are blind are particularly vulnerable and in need of outreach--currently only about 83 thousand blind people of all ages participate in the SSI program--about 23 thousand of these are over age 65.

The Older Americans Act has a fully developed network of over 600 area agencies on aging throughout the country which could play a vital role in outreach to blind and visually-impaired people.

Nutrition Programs (Title VI)

FY1988 Appropriations	FY1989 Appropriations	FY1990 Authorization	President's FY1990 Request	AFB Recommendation
7.5	7.4	19.0	7.4	19.0

We support the National Indian Council on Aging's request for increased funding for nutrition programs. The Administration on Aging, under the authority of the 1987 amendments authorized an increase in the number of nutrition sites for elderly Indians. The number of sites has been increased from 136 to 181 in FY 1989 yet the appropriation was not increased. The minority groups, in general, have a higher incidence of blindness than the population as a whole. Nutrition sites with adequate nutrition will be of great help to those who are unable to obtain and prepare meals for themselves, if they can participate in nutritional programs at tribal locations. With the appropriation of $7.4 million, the number of meals available to elderly Indians has been effectively decreased.

STATEMENT OF J. GARY MATTSON, EXECUTIVE DIRECTOR, EXCEPTIONAL PERSONS, INC., AND PRESIDENT, NATIONAL ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES

Senator **SPECTER**. I would like now to call on J. Gary Mattson, executive director, Exceptional Persons, Inc., Waterloo, IA, representing the National Association of Private Residential Resources. It's nice to see someone from Exceptional Persons, Inc.

Mr. **MATTSON**. Good morning, and thank you, Senator, for giving us the opportunity to testify before this subcommittee today.

As you indicated, I am president of the National Association of Private Residential Resources, and serve as executive director of Exceptional Persons, Inc., of Waterloo, the ARC of Blackhawk County, and UCP of northeast Iowa.

Our association currently represents more than 500 agencies in 49 States and the District of Columbia that together provide residential services to over 40,000 people with mental retardation and other developmental disabilities. Our members offer a full range of residential services in a variety of settings designed to enhance the development and self-dependence of those served. Funding for residential services vary from State to State and from agency to agency.

Association members staunchly support the entitlement approach to services for people with disabilities. It is critical in the delivery of quality services and for long-term planning.

When intervening forces, such as new rules, mandatory wage increases, et cetera, are applied, Medicaid reimbursement levels must increase to adequately address the new requirements. The impact on the private sector is particularly onerous when the costs of complying with the new requirements increase. Private providers in most States experience discriminatory treatment within the State reimbursement systems.

Although Medicaid law, section 1902(a)(13)(A), requires States to provide reimbursement levels that are:

> * * * reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards * * *.

In actual practice reimbursement levels in many States make it impossible for even the most efficiently and economically operated private facilities to comply with the mandated requirements.

Although States are providing the administration with assurances that they are complying with this provision of the statute, little attention is given to actual State reimbursement practices.

The private sector has a right to be treated more fairly. Federal money is supporting services in both privately and publicly operated facilities, and those receiving services have the right to expect quality wherever they reside.

To promote equal treatment and encourage quality services in both the public and private sectors, we ask that this subcommittee examine implementation of section 1902(a)(13)(A) of the Medicaid statute to assure that reimbursement levels permit facilities to comply with applicable requirements.

In addition, we strongly support the House Budget Committee recommendation that $200 million be added to the Medicaid budget authority in fiscal year 1990 to continue progress made with the home and community based waiver program by supporting important expansions of Medicaid entitlements to cover costs associated with increased prevention programs for women and children and community habilitation services for people with disabilities.

We also urge the inclusion of language in the fiscal year 1990 appropriation act to direct the administration to provide reimbursement for habilitation services to States that cover such services as clinical and rehabilitation services under their state Medicaid plans.

PREPARED STATEMENT

In our written testimony, we have also expressed support for several SSI initiatives, asked for realistic appropriations for social service block grants, and the full authorization level for the comprehensive living services. I respectfully refer you to that document and ask that our written testimony which we submitted be recorded in the record.

Senator **Specter**. It will all be made a part of the record.

Mr. **Mattson**. Thank you. We appreciate the time you have given us this morning.

Senator **Specter**. Thank you very much.

[The statement follows:]

STATEMENT OF J. GARY MATTSON

Good morning. Thank you, Senator Harkin, for giving us an opportunity to testify before this Subcommittee today.

I am President of NAPRR and serve as Executive Director of Exceptional Persons, Inc., of Waterloo; the ARC of Blackhawk County, and UCP of Northeastern Iowa.

Our Association currently represents more than 500 agencies in 49 states and the District of Columbia that together provide residential services to over 40,000 people with mental retardation and other developmental disabilities. Our members offer a full range of residential services in a variety of settings designed to enhance the development and self-dependence of those served. Funding for residential services varies from state to state and agency to agency. Association members staunchly support the entitlement approach to services for people with disabilities. It is critical in the delivery of quality services and for long-term planning.

MEDICAID

When intervening forces such as new rules, mandatory wage increases, etc., are applied, Medicaid reimbursement levels must increase to adequately address the new requirements. The impact on the private sector is particularly onerous when the costs of complying with new requirements increase. Private providers in most states experience discriminatory treatment within state reimbursement systems. Although Medicaid law, Section 1902(a)(13)(A), requires states to provide reimbursement levels that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards;" in actual practice reimbursement levels in many states make it impossible for even the most efficiently and economically operated private facilities to comply with mandated requirements. Although states are providing the Administration with assurances that they are complying with this provision of the statute, little attention is given to actual state reimbursement practices. The private sector has a right to be treated more fairly. Federal money is supporting services in both privately- and publicly-operated facilities, and those receiving services have the right to expect quality services wherever they are provided.

TO PROMOTE EQUAL TREATMENT AND ENCOURAGE QUALITY SERVICES IN BOTH THE PUBLIC AND PRIVATE SECTORS, NAPRR ASKS THIS SUBCOMMITTEE TO EXAMINE IMPLEMENTATION OF SECTION 1902(a)(13)(A) OF THE MEDICAID STATUTE TO ASSURE THAT REIMBURSEMENT LEVELS PERMIT FACILITIES TO COMPLY WITH APPLICABLE REQUIREMENTS.

IN ADDITION, NAPRR STRONGLY SUPPORTS THE HOUSE BUDGET COMMITTEE RECOMMENDATION THAT $200 MILLION BE ADDED TO THE MEDICAID BUDGET AUTHORITY IN FY 1990 TO CONTINUE PROGRESS MADE WITH THE HOME AND COMMUNITY BASED WAIVER PROGRAM BY SUPPORTING IMPORTANT EXPANSION OF MEDICAID ENTITLEMENTS TO COVER COSTS ASSOCIATED WITH INCREASED PREVENTION PROGRAMS FOR WOMEN AND CHILDREN, AND COMMUNITY HABILITATION SERVICES FOR PEOPLE WITH DISABILITIES.

NAPRR ALSO URGES THE INCLUSION OF LANGUAGE IN THE FY 1990 APPROPRIATIONS ACT TO DIRECT THE ADMINISTRATION TO PROVIDE REIMBURSEMENT FOR HABILITATION SERVICES TO STATES THAT COVER SUCH SERVICES AS CLINICAL OR REHABILITATION SERVICES UNDER THEIR STATE MEDICAID PLANS.

In our written testimony we have also expressed our support for several SSI initiatives; asked for realistic appropriations for Social Services Block Grants; and the full authorization level for the Comprehensive Living Services. In order not to exceed my time, I respectfully refer you to that document.

We appreciate the time you have taken to hear our recommendations and urge their adoption. I'll be glad to answer any questions you may have.

The National Association of Private Residential Resources currently represents more than 500 agencies in 49 states and the District of Columbia that together provide residential services to over 40,000 people with mental retardation and other developmental disabilities. Our members offer a full range of residential services in a variety of settings designed to enhance the development and self-dependence of those served. Most NAPRR members serve people at more than one site. Funding for residential services varies from state to state and agency to agency. Association members staunchly support the entitlement approach to services for people with disabilities. It is critical in the delivery of quality services and for long-term planning.

For purposes of this testimony, NAPRR has chosen to focus on four programs under the purview of this Subcommittee that are of particular concern because they provide significant support for residential services.

MEDICAID

It is estimated that about 800,000 people with developmental disabilities currently receive Title XIX Medicaid benefits. Thousands of individuals with severe mental and physical disabilities receive Medicaid assistance for long-term residential services in intermediate care facilities for the mentally retarded (ICFs/MR) and nursing facilities. Others receive assistance for residential and/or daily program services through their state's Medicaid Waiver for Home and Community Based Services, or access state services identified in their State Medicaid Plan.

We would like to take this opportunity to thank Congress for urging the Administration to publish long-overdue rules governing the operation of intermediate care facilities for the mentally retarded. Work on proposed new rules began in the early 1980s, but despite requests from state government, advocates and providers for their release, publication did not occur until the Health Care Financing Administration (HCFA) was encouraged by Congress to release them for public comment. The new rules published in 1988 are consistent with contemporary practice, particularly with respect to their emphasis on outcomes for people served. Preliminary reports indicate that there may be increased costs associated with implementation of the new rules, but that has not yet been confirmed.

When intervening forces such as new rules, mandatory wage increases, etc., are applied, reimbursement levels must increase to adequately address the new requirements. The impact on the private sector is particularly onerous when the costs of complying with new requirements increase. Private providers in most states experience discriminatory treatment within state reimbursement systems. Although Medicaid law, Section 1902(a)(13)(A), requires states to provide reimbursement levels that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards;" in actual practice reimbursement levels in many states make it impossible for even the most efficiently and economically operated private facilities to comply with mandated requirements. Although states are providing the Administration with assurances that they are complying with this provision of the statute, little attention is given to actual state reimbursement practices. The private sector has a right to be treated more fairly. Federal money is supporting services in both privately- and publicly-operated facilities, and those receiving services have the right to expect quality services wherever they are provided.

TO PROMOTE EQUAL TREATMENT AND ENCOURAGE QUALITY SERVICES IN BOTH THE PUBLIC AND PRIVATE SECTORS, NAPRR ASKS THIS SUBCOMMITTEE TO EXAMINE IMPLEMENTATION OF SECTION 1902(a)(13)(A) OF THE MEDICAID STATUTE AND STATE ASSURANCES THAT THEY ARE CONFORMING TO THAT AMENDMENT BY PROVIDING REIMBURSEMENT LEVELS THAT ARE "REASONABLE AND ADEQUATE TO MEET THE COSTS WHICH MUST BE INCURRED BY EFFICIENTLY AND ECONOMICALLY OPERATED FACILITIES IN ORDER TO PROVIDE CARE AND SERVICES IN CONFORMITY WITH APPLICABLE STATE AND FEDERAL LAWS, REGULATIONS, AND QUALITY AND SAFETY STANDARDS;" AND ASSURE THAT THIS IS OCCURRING.

Bills have been introduced in Congress to expand the services that can be reimbursed by Medicaid. Those of particular interest to NAPRR include: (1) phase-in of the mandatory coverage of pregnant women and infants with income of up to 185 percent of the poverty level; (2) phase-in of mandatory coverage of children up to 18 years of age who are at or under the poverty level; and (3) development of a state program of habilitation services for people living at home or in community living arrangements.

NAPRR STRONGLY SUPPORTS THE HOUSE BUDGET COMMITTEE RECOMMENDATION THAT $200 MILLION BE ADDED TO THE MEDICAID BUDGET AUTHORITY IN FY 1990 TO CONTINUE PROGRESS MADE WITH THE HOME AND COMMUNITY BASED WAIVER PROGRAM BY SUPPORTING IMPORTANT EXPANSION OF MEDICAID ENTITLEMENTS TO COVER COSTS ASSOCIATED WITH INCREASED PREVENTION PROGRAMS FOR WOMEN AND CHILDREN, AND COMMUNITY HABILITATION SERVICES FOR PEOPLE WITH DISABILITIES.

Of growing concern to NAPRR is the fact that approximately 40 percent of the states are currently threatened with the loss of Medicaid reimbursement for habilitation services that are funded within their state's definition of clinic or rehabilitation services. This could result in the loss of critical daytime programming for thousands of people with mental retardation and related disabilities. There is no basis in statute or regulation for the denial of reimbursement for such services. In fact, the Sixth Circuit Court ruled in 1985 that Ohio could include such services in its State Medicaid Plan.

NAPRR ALSO URGES THE INCLUSION OF LANGUAGE IN THE FY 1990 APPROPRIATIONS ACT TO DIRECT THE ADMINISTRATION TO PROVIDE REIMBURSEMENT FOR HABILITATION SERVICES TO STATES THAT COVER SUCH SERVICES AS CLINICAL OR REHABILITATION SERVICES UNDER THEIR STATE MEDICAID PLANS.

SUPPLEMENTAL SECURITY INCOME

NAPRR is supporting legislation being considered by Congress that would improve the Supplemental Security Income program. The Administration's FY 1990 budget proposes an estimated reduction of about $329 million in Federal budget outlay for the SSI program as compared to FY 1989. A portion of the decrease is due to the fact that just 12 payments will be made in FY 1990, while 13 will be made this year. The decrease is partially offset by a cost of living adjustment (estimated at 3.6 percent), payable in January 1990, and a projected increase in beneficiaries of 70,000 people in FY 1990. The Administration's budget includes no funding to increase benefits or to improve children's disability determinations, but proposes a decrease in the number of employee positions for the Social Security Administration. Cuts such as these would delay review and approval of benefits for SSI applicants and recipients.

NAPRR JOINS OTHER DISABILITY ADVOCATES IN SUPPORTING ADDITIONAL BUDGET AUTHORITY TO INCREASE SOCIAL SECURITY BENEFIT LEVELS, REMOVE INEQUITIES IN INCOME CALCULATIONS, AND IMPROVE ELIGIBILITY DETERMINATIONS FOR CHILDREN. THESE FACTORS MUST BE ACCOUNTED FOR IN THE APPROPRIATIONS PROCESS. IN ADDITION, NAPRR OPPOSES THE ADMINISTRATION'S RECOMMENDATION THAT STAFF POSITIONS FOR THE SOCIAL SECURITY ADMINISTRATION BE REDUCED, AND ASKS THAT CONGRESS INSTEAD INCREASE APPROPRIATIONS TO RESTORE SSA STAFFING LEVELS TO THE FY 1988 APPROPRIATED LEVEL.

SOCIAL SERVICES BLOCK GRANT

Conversion of the Title XX Social Services program to a block grant in the early 1980s, with a cut in appropriations, was supposed to be accompanied by a return of revenue sources to state and local governments. That part of the plan was never implemented. As a result, states have been left with reduced Federal funding and no new revenue sources to support community programs. If the FY 1981 funding level were adjusted for inflation, more than $4 billion would be required in FY 1989 just to maintain services provided in 1981.

The Administration has recommended that its "flexible freeze" proposal be applied to the Title XX program for FY 1990. The program has been frozen at $2.7

billion since FY 1987. Cuts at the beginning of the 80s and the three-year freeze have seriously eroded support for community-based services for people with disabilities. Although some programs would be increased under the "flexible freeze" concept, others would have to be cut to meet the overall FY 1990 outlay target. It is estimated that the "flexible freeze" could result in a cut of approximately 10 to 15 percent below the amount needed to maintain Title XX FY 1989 service levels into FY 1990 (adjusted for inflation). Such a cut for this important program would be unconsionable. Any reduction in funding for Title XX Social Services may well put additional demands on other more costly Federal programs — most specifically Medicaid.

NAPRR RECOMMENDS THAT $3.3 BILLION BE APPROPRIATED FOR THE TITLE XX SOCIAL SERVICES BLOCK GRANT PROGRAM IN FY 1990, AND SUPPORTS AUTHORIZING LEGISLATION TO PERMIT THAT LEVEL OF EXPENDITURE.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

The National Council on the Handicapped estimates that almost 400,000 people with disabilities could benefit from Independent Living Services under Title VII of the Rehabilitation Act. With more adequate funding, the Part A Comprehensive Independent Living Services Program, in conjunction with the Part B Centers for Independent Living program and the Part C Older Blind Individuals Independent Living Services program, could provide vital services to an ever-increasing number of individuals with severe disabilities. The Administration has proposed that the "flexible freeze" be applied to Independent Living Services programs in FY 1990. The estimated 10 to 15 percent cut that could be experienced under the proposed "freeze" would significantly reduce the current level of services.

NAPRR RECOMMENDS THAT $13.86 MILLION BE APPROPRIATED FOR THE TITLE VII PART A INDEPENDENT LIVING SERVICES PROGRAM, $28.98 MILLION FOR PART B CENTERS, AND $6.3 MILLION FOR THE PART C PROGRAM. (THESE AMOUNTS REPRESENT THE FULL FY 1990 AUTHORIZATION LEVELS).

NAPRR FURTHER SUPPORTS OTHER RECOMMENDATIONS OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES IN ITS ANALYSIS ENTITLED "THE IMPACT OF THE PRESIDENT'S FY 1990 BUDGET ON PROGRAMS FOR PEOPLE WITH DISABILITIES."

STATEMENT OF W. WINFIELD MC CHORD, JR., PRESIDENT, CONFERENCE OF EDUCATIONAL ADMINISTRATORS SERVING THE DEAF, INC.

Senator SPECTER. We will now call on Mr. Winfield McChord, Conference of Educational Administrators Serving the Deaf. Your statement will be made a part of the record, Mr. McChord, and you may proceed.

Mr. MCCHORD. Thank you. In the interest of brevity, I will just touch on the highlights and try to confine it to just a few sentences.

Senator SPECTER. Thank you.

Mr. MCCHORD. Our organization is comprised largely of the heads of residential schools for the deaf known as center schools. The majority of those are State schools for the deaf.

Those programs are generally ineligible for Public Law 94-142 funds and historically have relied on chapter I funds or, as it was previously called, Public Law 89-313 funds.

PREPARED STATEMENT

Our schools have lost population since the passage of Public Law 94-142. Likewise, we have found a much more diverse population of educational challenges. As a result, we are becoming much more expensive. We are providing lower ratio to serve that number of children, and we are having to call in more specialized talent in order to deal with their educational needs.

As a result, we are here this morning to encourage you to give full funding to chapter I funds in fiscal year 1990.

Thank you.

Senator SPECTER. Thank you very much. I very much appreciate your testimony, Mr. McChord, and we will consider it very carefully. We thank you for yielding back time.

[The statement follows:]

STATEMENT OF W. WINFIELD McCHORD, JR.

Mr. Chairman and members of the Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, I am Winfield McChord, President of the Conference of Educational Administrators Serving the Deaf.

The education of deaf children was the first special education effort in the western hemisphere. It was begun at the American School for the Deaf in Hartford, Connecticut, in 1817, by our founder Thomas Hopkins Gallaudet, for whom a prominent University one mile from this committee room was named. I am proud to be the tenth Headmaster of the American School for the Deaf and President of an organization that has been the most vociferous and articulate advocate for hearing impaired children.

The Conference of Educational Administrators Serving the Deaf, founded in 1868, is comprised of administrators in educational programs, clinics, governmental agencies, and teacher training programs serving deaf children, youth, and adults. The majority of its members has historically been the state-operated and private schools for the deaf, called "Center Schools," which are especially dependent on Chapter I, ECIA (P.L. 89-313) funds for the support of their programming.

This morning, I want (1) to encourage full funding, $148.2 million, for programs authorized under Chapter I, ECIA, and (2) to emphasize that the state-operated and private residential schools must continue to rely on Chapter I, ECIA, funding.

The Center Schools for deaf children sustained a significant reduction in student enrollments when P.L. 94-142 became the law of the land in 1976. However, today these schools are experiencing stability in their student populations. They serve fewer children, but the kinds of students they serve today are more complex and more diverse in terms of educationally handicapping conditions. The combination of smaller student populations and more diverse programming has been expensive and has required initiative, innovation, and resourcefulness. Chapter I, EICA, funds have made the difference. These funds have supported in-service training, parent education, development of new educational techniques to serve multihandicapped children, computer assisted instruction, and services for hearing impaired infants, to name but a few. Chapter I funds have made a difference in the quality of services and the morale of the professionals at the Center Schools. The continuation of full funding is clearly needed.

The funding sources for special education in the United States are local funds, state funds, and federal funds (P.L. 94-142 and Chapter I, EICA). The majority of Center Schools serving deaf children receive little or no funding from P.L. 94-142, due to state and federal guidelines, except in unusual cases where the funds come from the discretionary portion of a state's allotment. The Congress enacted P.L. 89-313 to serve handicapped children in Center Schools. The Congress enacted P.L. 94-142 to serve handicapped children in the public school setting. And the Congress enacted Chapter I, EICA, to enhance educational opportunities for handicapped children and guarantee continued funding for handicapped children in the Center Schools. The importance of these funds is clear. The only federal funding available to Center Schools is Chapter I, EICA.

Mr. Chairman, and members of the subcommittee, the Conference of Educational Administrators Serving the Deaf is strongly supportive of the goals and intent of Chapter I, EICA, and we urge your support in providing full funding of this critical legislation.

STATEMENT OF MARVIN KUEHN, PRESIDENT, NATIONAL COUNCIL ON REHABILITATION EDUCATION

Senator SPECTER. I would like to call on Mr. Marvin Kuehn, president of the National Council on Rehabilitation Education.

Mr. Kuehn, do you have a prepared statement?

Mr. KUEHN. Yes; it was submitted.

Senator SPECTER. Thank you, Mr. Kuehn. You may proceed. Your full statement will be made a part of the record.

Mr. KUEHN. Thank you very much.

Mr. Chairman, I am Marvin Kuehn, and I am a professor of rehabilitation education, and I am current president of the National Council on Rehabilitation Education.

The National Council on Rehabilitation Education is a national organization composed of rehabilitation educators, researchers, doctoral students, and other training specialists who are concerned about quality, preservice, inservice, and continuing education and training of a variety of rehabilitation personnel.

I am pleased to have this opportunity to testify before the subcommittee, and I would like to summarize my views. I would like to have our written testimony written into the record.

Senator SPECTER. It will be received as socn as we find a copy.

Mr. KUEHN. It was submitted.

I am testifying not only as the president of the National Council of Rehabilitation Education, but also as a consumer of rehabilitation services myself as a husband of a woman who is paraplegic and as the father of a son who has a spinal cord tumor and is suffering the stigma associated with that.

Over 20 years ago, my wife and I both received rehabilitation services and we both are very appreciative of those services. We feel like we probably would not have accomplished what we have been able to at this point without the services of those qualified professionals.

Even though a strong, effective rehabilitation training program was established and has been supported since 1954, the importance and the necessity for qualified personnel to provide efficient and effective services have often been overlooked. In addition to supporting preservice education, funds have also been used for continuing education and for inservice training of employed personnel to keep them abreast of innovative, technological developments. The result over the years has been an impressive network of educational programs based in U.S. colleges and universities, rehabilitation agencies, and continuing education programs.

Effective services are generally directly related to the qualifications of providers. Qualified is the key term because it indicates to the practitioner in performing his or her duties that they are ethical, trained, knowledgeable, and skillful.

More training or more trained personnel will not solve all the problems that exist regarding needy services. Training and research efforts can have a tremendous positive impact on client services if these efforts are combined with good leadership, professional preparation, and performance standards.

I would like to state that the demand for professionally trained personnel is greater than ever before because of the nature of the populations now being served, populations like those graduating from special education programs who complete their public school education are now being served by rehabilitation agencies. Medical technology is advancing, and these changes have created complex evaluation and service delivery problems. Groups, such as those limited by traumatic head injury, chronic mental illness, are receiving increased attention, as well as the needs of the deaf, blind, and individuals needing support of the work services.

If increased training is not provided, rehabilitation consumers will be denied the opportunity to maximize their employment potential or chance to become independent and escape the stigma and bondage of a welfare program.

PREPARED STATEMENT

Rehabilitation is an investment in human resources. It is not a welfare program. Disabled Americans who have received services through qualified professional rehabilitation personnel have returned far more in taxable earnings than the program has cost.

On behalf of NCRE, I appreciate the opportunity to speak in support of full funding, $37 million, as authorized, for rehabilitation training in fiscal year 1990.

Thank you.

Senator **Specter**. Thank you very much, Mr. Kuehn. We appreciate your testimony, and we will give it careful consideration.

[The statement follows:]

STATEMENT OF MARVIN KUEHN

The National Council on Rehabilitation Education (NCRE) is an organization composed of educators, researchers, training specialists, and doctoral students dedicated to quality education and training of a variety of rehabilitation personnel. If adequate numbers of qualified personnel were available, rehabilitation services could be provided to a greater percentage of the 36 million adult disabled Americans. These services emphasize identification of employment barriers faced by consumers, the evaluation of and selection of employment/work options, and maximizing opportunities for living as independently as possible.

I am pleased to have this opportunity to testify before the Subcommittee to express the views of NCRE regarding the critical need for knowledgeable, qualified rehabilitation personnel and to support full funding as authorized ($37 million) for rehabilitation training, in Fiscal Year 1990.

BACKGROUND OF FEDERAL SUPPORT FOR REHABILITATION TRAINING

The recent economic recession has had a devastating effect on the severely disabled. A higher proportion of disabled people have never worked and have been on some form of public assistance than persons in the general population; part of the reason for the high unemployment has been attributed to the shortage of qualified rehabilitation personnel.

As a nation we have committed ourselves to assisting the disabled, and in doing so we have turned tax consumers into taxpayers. In the 1984 Report to Congress by the Rehabilitation Services Administration, it was indicated for every $1.00 spent to return a disabled person to work, $18.00 were returned to the tax base upon their placement. Evidence of this commitment is seen in the fact that rehabilitation training was first authorized by Congress in 1954,and since then, federal funds have augmented state and local resources to support pre-service professional education for individuals in a variety of rehabilitation disciplines including: rehabilitation counseling, undergraduate rehabilitation services, job placement, vocational evaluation and work adjustment, rehabilitation facility administration, personnel to provide supported work services, independent living, rehabilitation of the blind, deaf, and mentally ill, physical and occupational therapy, audiology and speech therapy, mobility and orientation for the blind, physicians specializing in physical medicine and rehabilitation, and others. In addition to supporting pre-service education, funds have also been used for continuing education and in-service training of employed personnel to keep them abreast of innovative technological developments. The result, over the years, has been an impressive network of educational programs based in U.S. colleges and universities, rehabilitation agencies, and continuing education programs.

Even though a strong, effective rehabilitation training program was established and has been supported since 1954 , the importance of and necessity for qualified personnel to provide efficient and effective services has been overlooked. Effective services are generally directly related to the qualifications of providers. "Qualified" is the key term because it indicates that the practitioner, in performing his or her duties, is ethical, trained, knowledgeable, and skillful.

IMPACT OF FUNDING FOR REHABILITATION TRAINING

Personnel shortages, advancing technology, turnover rates and retirements in both direct service agencies and higher education, and the complexity of services required by new consumer populations are all factors contributing to an increasing demand for qualified rehabilitation professionals. In many cases, persons who previously would have died are now living as medical advances and related technologies have greatly improved. Health care services are obviously important; however, an over-riding concern of NCRE is the need for qualified personnel to address the vocational (employment) and independent living needs of persons with disabilities. In addition, a significantly large number of professionals with extensive experience and appropriate educational backgrounds in rehabilitation are reaching retirement age; this factor alone may be the most critical problem for NCRE. IT IS IMPERATIVE FOR US TO BE ABLE TO ATTRACT NEW, TALENTED INDIVIDUALS INTO REHABILITATION EDUCATION. Today, qualified women, minorities, and disabled are particularly in short supply; economic realities, promotions and upward mobility, and the opportunities for higher salaries in other fields are luring many doctoral students and new, young faculty out of rehabilitation.

More trained personnel will not solve all the problems that exist regarding services; however, increased funding for programs that have outstanding track records for preparing "qualified personnel" and for programs that have integrated innovative approaches and updated curricula to reflect the needs of new consumer populations, we believe, is justified. Training and research efforts can have a tremendous positive impact on client services if these efforts are combined with good leadership, professional preparation and performance standards.

The major concerns of the National Council on Rehabilitation Education regarding the future of rehabilitation training include the following:

First, state vocational rehabilitation agencies continue to experience high annual turnover rates of 14% to 16% in direct service personnel. In the state agencies alone, attrition would consume all of the approximately 1500 graduates currently completing M.S. and B.S. academic programs in rehabilitation. This situation is likely to get worse if we fail to recognize the value and long-range economic benefits of federal support for rehabilitation training.

Second, the demand for professionally trained personnel is greater than ever before because of changes in the nature of the populations now being served in the state-federal program. An increasing number of students involved IN SPECIAL EDUCATION PROGRAMS ARE NOW ELIGIBLE FOR TRANSITION SERVICES, after they complete their public school education, through state rehabilitation agencies. Medical technology is advancing, and more lives are being saved. These changes have created complex evaluation and service delivery problems. Groups such as those limited by traumatic head injury are receiving increased attention as well as the needs of the deaf, blind, and individuals needing "supported work" services. With deinstitutionalization efforts of the late 1970's, the need for "transition experts" that could serve the mentally retarded, psychiatric, and aging populations became evident.

Continuing education is a third area of need that must be addressed to insure that personnel already in the field also maintain up-to-date knowledge and skills, keep up with rapidly changing technology, and respond to changing priorities and needs within the rehabilitation system. If such training is not provided, rehabilitation consumers will be denied the opportunity to maximize his/her employment potential or chance to become independent and escape the stigma and bondage of a welfare program.

Fourth, we in the rehabilitation professions believe a crisis situation has arisen relative to recruiting and retaining "qualified rehabilitation personnel". To be very frank, many leaders in the field estimate that $60 million would be needed for rehabilitation education and training to fully up-date and upgrade training programs and to recruit and retain the most talented students to the various rehabilitation disciplines and professions. Ultimately, if educators and researchers cannot keep pace with technology and the needs of new special disabled populations, the social security system or state welfare programs will begin to see increases in applications for benefits with minimal likelihood of these individuals ever attaining meaningful employment or independence from a welfare-type support program.

JUSTIFICATION FOR INCREASING SUPPORT FOR REHABILITATION TRAINING

1. While the capacity of the state-federal vocational rehabilitation program and related service programs and agencies is estimated at approximately 1,000,000 persons, more than 600,000 individuals (Trietel, 1979) become disabled or limited in substantial ways that make them unemployable each year. According to the National Council on Disability in the publication Focus (Winter 1989), "two-thirds of all disabled Americans between the ages of 16 and 64 years of age are not working." Because of insufficient funds for rehabilitation services and inadequate numbers of trained rehabilitation personnel, billions of dollars each year are required in subsistence payments to individuals who are not served.

2. In a comprehensive research study (National Council on Rehabilitation Education,1987), from the National Institute on Disability and Rehabilitation Research (NIDRR) results obtained documented the need for qualified practitioners, the unquestionable value of pre-service (M.S.) education, and that M.S. persons demonstrate more efficient and effective services than untrained personnel.

3. Rehabilitation supervisory personnel are needed to manage rehabilitation facilities across this nation. Placement specialists are crucial in terms of facilitating employer contacts and assisting the severely disabled in finding feasible employment. Qualified evaluation personnel trained to assess individuals who are deaf, blind, the mentally ill, or traumaticly brain injured, are also expected to be in short supply.

4. While many of the directors of state rehabilitation agencies and the clients of vocational rehabilitation services themselves advocate the master's degree as the entry-level for rehabilitation practice, it is estimated that less than half the rehabilitation counselors employed by state agencies have a master's degree. As the supply of trained rehabilitation personnel is reduced by fewer graduates, attritions to other more lucrative fields and other factors such as higher salaries, also diminish the pool of professionally trained workers who can provide the quality services desired.

5. Two recent studies authorized by the Department of Education (Pelavin, 1988 and 1989) both clearly documented that there are shortages of qualified rehabilitation personnel available for working with severely disabled persons. If funding is not provided at the full level authorized, this will further reduce the severely disabled person's opportunity to be provided services by a qualified individual.

SUMMARY

The value of up-to-date professional training and its impact on the quality of service delivery to consumers has often been underestimated. Recent research evidence (Szymanski, 1988) from the state of New York clearly validates the positive effects that qualified rehabilitation personnel can have on the provision of services. Maximizing the inclusion of persons with disabilities in the work force and mainstream of society (including minorities) can only occur if more federal funds are targeted for rehabilitation education and training. Rehabilitation is an investment in human resources; it is not a welfare program. Disabled Americans who have received services through qualified professional rehabilitation personnel have returned far more in taxable earnings than the program has cost. It would seem to be poor economic reasoning and unhealthy humanitarian concern to minimize the need for competent service providers which are so vital to the delivery of quality services to the disabled particularly when the ultimate goal is employment and/or self-sufficiency. On behalf of NCRE, I appreciate the opportunity to speak in support of full funding ($37 million as authorized) for rehabilitation training for Fiscal Year 1990. We commend this Subcommitee for the recognition of and insight into the needs of persons experiencing severe disability and the role and value that professionally trained personnel can have on the employment success of disabled consumers and their efforts to gain employment and independence.

STATEMENT OF JUSTIN DART, NATIONAL REHABILITATION ASSOCIATION

Senator SPECTER. Now I would like to call on Mr. Justin Dart, National Rehabilitation Association. Mr. Dart, your full statement will be made part of the record, and you may proceed at this time.

Mr. DART. Mr. Chairman, it is a privilege to appear before this distinguished committee. Millions of my colleagues in the disability community and I applaud the sponsorship by Chairman Harkin and many of you of the Americans with Disabilities Act. We commend you all, all of the members of your committee and your staff, for your support over the years for the independence and equality of Americans with disabilities.

I do speak today as president-elect of the National Rehabilitation Association.

The programs and expenditures authorized by the Rehabilitation Act of 1973, as amended, have proven to be among the best investments that this Nation has ever made. Millions of persons with disabilities have been emancipated from unjust, unwanted, unproductive welfare dependency and enabled to become proud, productive, tax-paying participants in the mainstream of society. The economy and the quality of life of the Nation has benefited immensely.

I strongly recommend your support for full funding of the programs authorized by the act, and I will briefly mention a few.

First, the basic State rehabilitation program is the indispensible, rock-solid foundation for the eventual independence and equality of all Americans with disabilities. Among those administering this program are some of the finest, most effective human beings that I have ever known.

In the early 1950s when I as a recently disabled person, wanted to attend the university, my local rehabilitation counselor in Houston, TX, was the only individual I knew in this world who supported and encouraged me to succeed in the face of massive physical and attitudinal barriers that existed in those days.

Second, independent living is the process and philosophy of the future through which previously dependent individuals are trained and empowered to participate fully in the decisions which control their lives.

Third, expanded rehabilitation training is absolutely essential to meet the needs of increasing millions of persons with disabilities.

Fourth, supported employment services for persons with severe disabilities is the iceberg tip of a positive revolution in the productivity and quality of life of this Nation, and I recommend not only full funding, but expanded funding in the future.

Fifth, newly established technology-related grants will lay the foundation of the 100-percent accessible, superproductive America of the future.

Sixth, the National Council on Disability under the able leadership of Sandra Parino is shaping the comprehensive national disability policy that this Nation must have to meet the needs of a population of persons with disabilities which has reached 43 million and is rapidly growing. The historic Americans with Disabilities Act is just one of the council's outstanding products.

Seven, projects with industry, reaching out in a special way to private sector employers of persons with disabilities, has proven to be very effective.

PREPARED STATEMENT

Mr. Chairman, the rehabilitation and disability rights programs which you have supported over the years have resulted in positive miracles in the lives of millions of persons like myself. I personally want to thank you from the bottom of my heart. I look forward to working with you and your colleagues for the passage of the Americans with Disabilities Act and the expansion of the services which make ADA rights real in everyday life.

Thank you very much.

Senator SPECTER. Thank you, Mr. Dart.

[The statement follows:]

STATEMENT OF JUSTIN DART

Mr. Chairman, Members of the Subcommittee, the National Rehabilitation Association is an organization whose purpose is solely to advance rehabilitation for persons with disabilities.

The nearly 17,000 members of the National Rehabilitation Association and its seven divisions -- the Job Placement Division (JPD), the National Association of Rehabilitation Instructors (NARI), the National Association of Rehabilitation Secretaries (NARS), the National Rehabilitation Administration Association (NRAA), the National Association for Independent Living (NAIL), the National Rehabilitation Counseling Association (NRCA), and the Vocational Evaluation and Work Adjustment Association (VEWAA) -- express our appreciation for giving us the opportunity to present our views.

THE REHABILITATION ACT OF 1973, AS AMENDED

The Rehabilitation Act of 1973, as amended, is one of the most complete and well-balanced pieces of legislation in the human services field and a cornerstone in the Nation's effort to assist Americans with disabilities in their efforts to achieve meaningful employment and self-sufficiency.

People with mental and physical disabilities comprise a significant portion of the Nation's population - an estimated 36 million individuals. The size of the disabled population is not static, but continues to grow -- through accidents, injuries, illnesses, and birth defects -- at an estimated rate of 500,000 annually.

Our Nation's past investments in this program have returned significant dividends to our Nation's taxpayers, and more importantly, to the persons with disabilities who receive rehabilitation services. Few, if any, programs funded by the Federal government consistently return so many benefits, both financial and personal, to all segments of our society.

The Rehabilitation Act Amendments of 1986 placed new requirements on the State-Federal Rehabilitation Program. The

Rehabilitation Act was amended to (1) require each State Agency to provide Rehabilitation Engineering Services, (2) to assist State Rehabilitation Agencies in the establishment of Supported Employment Service Delivery Programs in each State, and (3) by other changes which, in conjunction with scarce resources, place more pressure on an already-overburdened service delivery system. These are worthy goals. They, however, place additional demands on a service delivery system which is currently overburdened, and only, due to the lack of resources, able to provide services to 1 out of every 20 individuals eligible to receive such services.

In light of the fact that 66 percent of individuals with disabilities aged 16 and over report that their disability prevents them from working and that individuals with disabilities comprise the most underemployed segment of our society, it is vital that State, Federal, and private partners cooperate to provide the assistance necessary for individuals with disabilities.

REHABILITATION BASIC STATE SERVICE GRANTS

We are recommending an appropriation level of the full authorization amount for the Basic State Vocational Rehabilitation Program, the foundation of the programs authorized in the Rehabilitation Act, as amended, of $1,705 million. Throughout its 69 year existence, this program has served millions of Americans with disabilities and has rehabilitated and placed well over 5.5 million people into meaningful, productive jobs.

A national survey of State Vocational Rehabilitation Agencies provides pertinent information as to the ability of the Rehabilitation Program to respond to the existing needs of people with disabilities. The results conclude:

- In FY 1989, the Federal/State Rehabilitation Program will serve an estimated 953,909 people with mental and physical disabilities.
- Should the Congress only appropriate the President's request of $1,502 million, State Agencies estimate that they will

be able to serve only 7,037 more people with disabilities, an increase of less than one percent over this year.

o Should the Congress appropriate $1,705 million in FY 1990, the fully-authorized amount, State Rehabilitation Agencies will be able to serve an additional 105,474 persons with disabilities, an 11 percent increase over the number served in FY 1989.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

NRA recommends an investment of $13.86 million for the programs under Part A; $28.98 million for Part B; and $6.3 million for Part C, the fully authorized levels. Under Part A of the Independent Living Program, State Agencies provide, or arrange for the provision of, any service which may enhance the ability of a person with a disability to live independently and function within the community and, if appropriate, secure and maintain employment. Currently, under Part B of the Program, only 40,000 individuals are being served by 141 Federal Grant recipients who operate over 189 Independent Living Centers. Under Part C, grants are provided to State Rehabilitation Agencies and to other public or private nonprofit agencies or organizations to assist older persons who are blind to live independently.

REHABILITATION TRAINING

We are recommending an investment of $37 million for Rehabilitation Training Programs. Rehabilitation Training is a critical element in providing services to Americans with disabilities. Grants are made to help ensure that adequately skilled personnel are available to provide rehabilitation services to persons with disabilities. Because rehabilitation plans are tailored to each person with a disability, vocational rehabilitation depends upon a well-prepared "qualified" professional to deliver a wide range of services.

The President's recommendation of $30.134 million for Rehabilitation Training would not allow the Program to begin to address areas of critical training needs and personnel shortages.

The NRA recommends the full authorization level for Rehabilitation Training to help meet the added demand for trained personnel to work with the severely disabled and professionals in supported employment as called for by Congress. There also exists significant unmet training needs in rehabilitation facilities. Those needs arise from the current demands placed on community providers in the areas of new technology, emerging of new populations, and an increasing number of individuals with severe disabilities who have previously been unemployed or underemployed.

SUPPORTED EMPLOYMENT SERVICES

The NRA recommends an investment of $29.73 million for Supported Employment Services for persons with severe disabilities. The NRA recommends that Supported Employment be funded at the full amount authorized under Public Law 99-506, the Rehabilitation Act Amendments of 1986. This two-year old program holds great promise for securing employment for individuals who have not traditionally been eligible for rehabilitation services. Several thousand additional persons with severe disabilities could be served in FY 1990 if the program is fully funded.

TECHNOLOGY RELATED ASSISTANCE GRANTS

The NRA recommends that $20 million be provided for Grants to States and $6.5 million for Programs of National Significance for the newly established Technology-Related Assistance Grants. This program which was created in 1988 was created to increase access to assistive technology devices and services for individuals of all ages and disabilities. Without adequate funds, the states' progress will be impeded, and people with disabilities will continue to be denied access to the tools they need to receive an education, seek gainful employment and participate fully in society.

PROJECTS WITH INDUSTRY

We recommend an investment of $19.149 million, the fullu authorized level, for the Projects With Industry (PWI) Program. The new dollars provided by the increase should be specifically targeted to new and existing projects, thereby allowing the most successful projects to expand their business and industry base to facilitate greater private sector involvement, as well as allowing new and innovative projects the opportunity to replicate the proven success of PWI.

CONCLUSION

Mr. Chairman, the Rehabilitation Act and the programs it authorizes signifies our society's recognition of its responsibility to provide citizens with disabilities the opportunity to be full participants in the mainstream of life.

We thank you Mr. Chairman and Members of the Subcommittee in advance for appropriating funds for the Rehabilitation Program at the levels we have recommended in this testimony.

Thank you.

STATEMENT OF RONALD B. HOUSE, PH.D., PRESIDENT, ASSOCIATION FOR THE EDUCATION OF REHABILITATION FACILITY PERSONNEL

Senator SPECTER. Now we will call on Mr. Ronald B. House, Association for Education of Rehabilitation Facility Personnel. Your full statement will be a part of the record, Dr. House, and you may proceed.

Dr. HOUSE. Thank you. I would like to just summarize what I was going to say.

Senator SPECTER. Thank you.

Dr. HOUSE. Thank you for agreeing and allowing me to be present today.

I am Ronald B. House. I am president of the Association for Educators of Rehabilitation Facility Personnel. I represent about 18 universities and colleges, members of continuing education programs that serve disabled people, professionals, and provide services to disabled people throughout the United States.

One common denominator that we have is that we provide education and training to organizations and individuals that serve disabled people.

Our main focus is on management training and professional development training. Currently, we provide management professional training to employees of over 4,700 rehabilitation organizations throughout the United States. We serve over 800,000 people each day and 1.6 million people annually.

The work force that we work with is approximately 65,000 personnel, and we respond to the training needs of over 9,000 rehabilitation facilities that are both community based throughout the United States.

We did this last year on a management budget of over $2 million and this covered all disciplines, approximately undergraduate programs, graduate programs, and continuing education programs. For that group we had about $30 million. This was out of a $1.5 billion budget.

Several regions throughout the country this past year were left uncovered because there was not enough money within that $2 million budget to provide training to those regions. The regions were region 9, California, Hawaii, and Utah; region 2, which was New York and New Jersey; and Texas and Arkansas, which was region 7.

At times it's a zero sum game. There is just a certain amount of money and among the 10 regions, certain regions are left uncovered without a Federal program to implement the management or professional development training.

I'm here today to request that there be enough funds to cover all Federal regions throughout the United States in order to implement the rehabilitation services administration program throughout the country.

I'm also asking that the training appropriation be reviewed and looked at and possibly doubled to $60 million for the fiscal year 1990.

I would like to address four major needs. One of these needs can be done with new legislation, save money, and also provide a more comprehensive program, and that is to develop a facility administration continuing education program in each of the 10 regions. Now, there is no identifiable program in any of the regions. There are three to four programs. The overhead is duplicative. There is not consistency. The grants are often for 1 to 3 years, and they overlap. This would just require a change in the legislation to have a recognized facility administration continuing education program which would consolidate funds, offer continuity, and have an identifiable program in each region.

Also, I think there is another need to maintain the personnel in this field. Last year, according to my research and other research that was done by Crimando, 24 percent unemployment and turnover occurred in agencies from 50 to 99 employees.

Senator SPECTER. Dr. House, do you have three more issues that you want to discuss because if you do, please summarize.

Dr. HOUSE. I'll summarize them really quickly.

PREPARED STATEMENT

I would also like to support employment. I think it is another major need which Justin Dart emphasized as well.

I would also like to see a response to the information and technology needs of people with disabilities.

I support the National Coalition.

And I would like to thank you for presenting today.

Senator SPECTER. Thank you very much. We will consider very carefully what you have requested.

[The statement follows:]

STATEMENT OF RONALD B. HOUSE

I am Ronald B. House, Ph.D., President of the Association for the Education of Rehabilitation Facility Personnel (A.E.R.F.P.) and a faculty member in the New York State School of Industrial and Labor Relations at Cornell University. I am speaking today on behalf of the Association for Educators of Rehabilitation Facility Personnel, as the current President of this organization. A.E.R.F.P. represents 18 universities and colleges concerned with providing training and education to the personnel employed by organizations providing a variety of services to individuals with disabilities such as rehabilitation facilities, supported employment programs, independent living centers, and community residences. It also represents members of programs that have a long history of excellence such as the International Center for Disability (ICD) in New York State, and a number of professionals or individual members that have knowledge, and distinctive expertise in the provision of professional services for both organizations and individuals that serve individuals with disabilities.

The one common denominator of all members of this organization is that they have the knowledge and skill to provide a service in the form of education and training to the many professionals serving individuals with disabilities. Currently there are approximately 4,700 rehabilitation facilities and another 800 day activity centers or 5,500 facilities in the United States. These facilities serve approximately 800,000 clients per day and 1.6 million annually (Menz, 1987). In addition, there are 400 independent living programs and several hundred community-based programs. We represent an educational program that responds to the human resource development needs of over 9,000 rehabilitation facilities and community-based employment programs across the United States. We have done so through a variety of programs. The foremost of which has been the Rehabilitation Services Administration grant program to provide training and education through regional and national grants both to the undergraduate, graduate, and continuing education program throughout this country. Our membership includes the continuing education centers of universities and colleges in each of the ten regions; and each of the federal ten regions also contains a variety of federally-sponsored programs whether it be evaluation, work adjustment, supported employment, rehabilitation administration, or direct workshop personnel grants. The common denominator, once again, is that we are providing education and training to organizations and individuals that provide services to disabled persons.

Harris and Associates (1986) indicate that two-thirds of all Americans with disabilities, between the ages of 16 and 64, are not working but want to have a job. The end goal for the organizations we serve is placement in competitive employment for individuals with disabilities and the implementation of the state-federal Rehabilitation Services program. The program to date has had 30 million dollars earmarked specifically for meeting the training needs of rehabilitation services personnel. I am here today to request that funds be allocated that will enable us to respond to the ever greater training needs of the personnel which we serve. The State-Federal rehabilitation services system has an annual budget of 1.5 billion dollars. A manpower development dollar amount of 30 million compared to the size of the overall budget is very inadequate. I strongly urge you to consider at least doubling the training amount to include a minimum $60 million dollar allocation for FY 1990. This will enable us to better meet the current demands of rehabilitation source personnel group growing in numbers and in need for expanded training opportunities to keep abreast of current information on how to better meet the employment needs of disabled persons.

Rehabilitation programs require staff who are well prepared, skilled, and sensitive to the diverse challenging needs of persons with disabilities. Rehabilitation facilities serve the most severely disabled clientele of the state/federal vocational rehabilitation system. Over one million persons with severe disabilities each year are served by 65,000 employees in more than 4,000 rehabilitation facilities. In response to personnel shortages, there are also management, professional and staff training needs. I would like to address four areas to meet these needs: 1) Development of a new facility administration delivery system, 2) Developing human resources and reducing turnover, 3) Community-based and Independent Living Programs, and 4) Information and Technology needs.

1). A.E.R.F.P. members recently approved a resolution to recommend to Congress and The Rehabilitation Services Administration (RSA) "to create Regional Rehabilitation Facility Administration Continuing Education Programs (RRFACEP) as the single primary facility personnel training resource in each region. The RRFACEP's would be substantially funded to administer technical assistance and post-employment personnel training related to community supported employment programs and other facility vocational services". This new federal grant training program would provide one identifiable program for the delivery of management training. Other advantages are that it would consolidate several grant programs for facilities into one grant, reduce the number of government grant programs, cut administrative overhead cost and provide for continuity of training services to deliver social policy for training that has not previously been available.

The training recommendation was presented to the Personnel Development and Training Committee of C.S.A.V.R. and approved by the Committee (April 10, 1989) to be recommended to the general body for further study and discussion. Several state directors agreed with the request for greater funding and the need for additional training resources.

2). There is a continuing need to develop rehabilitation service personnel. A 1986 study on turnover of rehabilitation facilities in the United States (Crimando, 1986) on rehabilitation facilities having 50-99 employees, indicated that approximately 24 percent leave in one year.

If we look at this as a basis of 100 people being employed by one human service organization, that is two people per month or 24 per year that are saying good bye, and the organization is saying hello to another 24 to replace them. In some cases, they are not able to fulfill the loss due to turnover, and while others have been able to meet the demand but it is with great stress and strain on the education and training resources that are available.

The cost per replacement of personnel is approximately $3,000.00 and could be as high as $4,500 (Example with 12 people leaving, the replacement cost would be 12 x $3,000 or $36,000 to $54,000 each year per facility). The community-based programs, which have similar problems to rehabilitation facilities, in one study (Welch, 1988) reported that job coaches remained on the job only 14 months.

While the cost is high and disruptive, other areas are also disruptive such as services to disabled people, staff morale and productivity. These issues must be addressed to provide support to maintain and retain a management and professional staff.

3). The educators of facility and community-based training programs are assisting in the implementation of the integration of disabled people into the workplace. One means of achieving integration is by improving the professional training of evaluators, vocational education, and supported employment personnel. The development of trained professionals of supported employment staff and management is a recognized goal of A.E.R.F.P. That demand must be met in order to meet the goals and objectives of the Rehabilitation Services Administration program.

4). There is also a growing need to respond to the information and technology needs of people with disabilities. (Public Law 99-506-1986) We advocate a planned program to meet these facility training needs through the training program within the Rehabilitation Services Administration. We also request national coverage on a regional basis in the areas of rehabilitation facility administration, supported employment, independent living, vocational evaluation and work adjustment. These training categories are critical to the improved delivery of rehabilitation facility services throughout the United States and to the quality of life and choices afforded to persons with disabilities.

I would like to thank you for your attention and the opportunity to present this testimony to you today on behalf of the AERFP membership. Thank you.

STATEMENT OF JOSEPH A. SNYDER, EXECUTIVE DIRECTOR, PENNSYLVANIA OFFICE OF VOCATIONAL REHABILITATION, COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Senator SPECTER. I would like now to call on Mr. Joseph Snyder, executive director, Pennsylvania Office of Vocational Rehabilitation. Welcome, Mr. Snyder, and you may proceed. Your full statement will be made part of the record.

Mr. SNYDER. Thank you, Senator Specter. I am glad to have a chance to testify on behalf of my fellow State administrators of vocational rehabilitation members of the council and also to echo Justin's support for the basic grant portion of the rehabilitation program which really is the lifeblood of vocational rehabilitation, as Justin called it, the solid basis on which the vocational rehabilitation program stands.

Last year the money that was appropriated for basic State vocational rehabilitation grants served 918,876 people with disabilities. In Pennsylvania, we were able to rehabilitate 11,500 people and over 8,500 of those people were placed into competitive employment. Over one-fourth of those folks had been recipients of public assistance and other types of public grant support.

We found that the competitive earnings of the people who were placed in employment in Pennsylvania last year were over $94 million, a significant return, I think, to the economy. That shows you what the estimate in people can do in vocational rehabilitation.

Nationally, 218,183 people with disabilities were rehabilitated into employment.

But our best estimates are that State rehabilitation agencies are only able to serve 1 out of 20 people eligible due to the scarce resources existing nationally now.

We are also facing a growing disabled population. The people living longer, people that are victims of traumatic injury are living because of advances in medical science. We have emerging disabilities with the increasing population who have AIDS and now the children of crack addicts—in Philadelphia, I think, it is one out of every four live births now are to mothers who are addicted to a substance, and those children are born disabled. They will be entering special education systems.

We are also alarmed at the purchasing power of the appropriation has increased only about 2 percent over the past 8 years plus. That means the program is serving fewer people, expending more money for adequate services, and trained staff and equipment. We feel that we are doing exactly what Congress has asked us to do. We are working with an increasingly severely disabled population. I think we are doing our job very well.

The money that we invest in people, that you have invested in people through us, is reducing the Federal deficit because people are going back to work. They are paying taxes. The accepted rule of thumb is that every dollar invested in vocational rehabilitation returns over $10 to State and Federal and local treasuries. It is a sound investment of public money.

PREPARED STATEMENT

While we focus today on just the Rehabilitation State Grant Program, we are pleased to join our other colleagues in supporting the areas like independent living, supported employment, the other portions of the act, rehabilitation training, and we strongly support the testimony that you have heard today from our colleagues who support vocational rehabilitation.

Senator SPECTER. Thank you very much, Mr. Snyder. Thank you for finishing within your time.

It is discouraging to hear that only 1 in 20 are being served, and if the number grows larger, we will do the best we can to stretch the dollars.

[The statement follows:]

STATEMENT OF JOSEPH A. SNYDER

The Council of State Administrators of Vocational Rehabilitation is the association comprised of all of the chief administrators of the public rehabilitation agencies providing services to persons with disabilities in the fifty states, the District of Columbia, and our Nation's territories.

These agencies constitute the state partners in the State-Federal Program of Rehabilitation Services for persons with mental and/or physical disabilities, as authorized by the Rehabilitation Act of 1973, P.L. 93-112, as amended.

The Rehabilitation Act is recognized as the most complete and well-balanced legislation in the human services field.

Its purpose is the provision of comprehensive services to persons with mental and/or physical disabilities, enabling them to re-enter the workforce or obtain employment for the first time, and to become independent of public assistance, publicly-funded health care, or family support.

The provision of these services results in a direct savings to government, as competitive work generates increased tax revenue, and as decreased dependence saves public assistance and other expenditures.

In the Rehabilitation Act, provisions are included for (1) a comprehensive and individually-tailored program of rehabilitation services to eligible physically and/or mentally handicapped individuals; (2) an innovation and expansion program; (3) a training program; (4) a research program; (5) a special projects program; (6) a rehabilitation facilities program; (7) a comprehensive services program for independent living; and (8) a supported employment program.

VOCATIONAL REHABILITATION SERVICES; BASIC STATE GRANTS

Section 110

FY 1990 CSAVR RECOMMENDATION....................$1,705,000,000
FY 1990 AUTHORIZATION...........................$1,705,000,000

Basic State Service Grants are the lifeblood of the Vocational Rehabilitation Program, financing the provision of vocational rehabilitation services to eligible individuals with mental and physical disabilities.

These Federal dollars, matched with state monies, permit State Rehabilitation Agencies to provide, or contract with private organizations and agencies to provide, individualized, comprehensive services to persons with mental and/or physical disabilities, for the purpose of rendering these individuals employed and independent.

Such services may include evaluation; comprehensive diagnostic services; counseling; physical restoration; rehabilitation engineering; prosthetic devices; the provision of various kinds of training and training supplies, tools and equipment; placement; transportation; post-employment services; and any other service needed to rehabilitate an individual into employment.

For Fiscal Year 1988, the $1,379,500,000 appropriated for Basic State Vocational Rehabilitation served 918,876 people with disabilities, of whom an estimated 62.5 percent will be rehabilitated into employment.

Despite this expenditure, there still are not sufficient funds to serve all those eligible, disabled people who have the potential and desire to work and who need rehabilitation services to obtain employment and self-sufficiency.

Alarmingly enough, our best estimates are that State Rehabilitation Agencies are able to serve only one out of every twenty people who are eligible, due to scarce resources.

State Rehabilitation Agencies, in carrying out the mandate of the Act to give priority of service to the rehabilitation of individuals who are severely disabled, are finding that the costs, in time, effort, and money of serving this group are great -- much greater than the cost of rehabilitating less severely disabled people. (Over 50 percent more costly than those services to persons who are not severely disabled).

In spite of this, it is alarming to note that, according to the Congressional Research Service, the purchasing power of the Federal Rehabilitation Appropriation increased by only 1.8 percent from 1980 to 1988.

This means that the Program is serving fewer people, while expending more money for adequate services, adequately-trained staff, adequate equipment, and adequate facilities.

65.5 percent of all individuals served by State Rehabilitation Agencies in FY 1988 were described as being "severely disabled" by the Federal Rehabilitation Services Administration.

With these statistics in mind, **the Council strongly urges that the Congress provide Federal appropriations for Basic State Vocational Rehabilitation Services in the amount of $1,705,000,000 for Fiscal Year 1990**.

A recent CSAVR Survey of all State Rehabilitation Agencies found **that with a Congressional appropriatiation of $1,705 million for FY 1990, an additional 105,000 people with disabilities will receive these vital rehabilitation services.**

The justification for higher funding levels stems from the purpose for which the money is spent--the prevention of an incalculable waste of human potential--a purpose on which no price tag can be placed.

Appropriating additional monies for Vocational Rehabilitation Services reduces the Federal Deficit.

Over the decades, Vocational Rehabilitation has more than paid for itself by helping persons with disabilities increase their earning capacity; by freeing family members to work; and/or by decreasing the amount of welfare payments, health services, and social services they might need; as well as by assisting them to become taxpayers.

The Congressional Budget Office has stated that "a reduction of funds for rehabilitation ... would generate increases in other parts of the federal and state budgets."

There is a return to Federal and state treasuries of over ten dollars for every dollar spent for Rehabilitation Services, according to the Rehabilitation Services Administration of the Department of Education.

Funds appropriated for Vocational Rehabilitation are a sound investment of the Public's money.

OTHER PROGRAMS AUTHORIZED BY THE REHABILITATION ACT

The CSAVR strongly supports adequate funding for all Sections of the Act, and wholeheartedly joins with the recommendations and rationale provided this Subcommittee by other Organizational and Advocates.

These call for FY 1990 funding at the full authorization level for Rehabilitation Training and Research; Comprehensive State Independent Living Services; Independent Living Centers; Independent Living for Older Blind Individuals; Supported Employment State Grants; and for the other service programs and demonstration projects authorized by the Rehabilitation Act.

In addition, the CSAVR strongly encourages the appropriation of sufficient funds to fully implement the State Grants and Technical Assistance Projects under the "Technology-Related Assistance for Individuals with Disabilities Act of 1989."

Attached is a chart showing the recommendations of the CSAVR for the major service Programs authorized by the Rehabilitation Act.

While the CSAVR's Statement focuses on major service delivery components of the Rehabilitation Act, the CSAVR supports adequate funding for all Sections of the Act, and wholeheartedly joins with the recommendations and rationale provided this Subcommittee by other Organizations and Advocates.

RECOMMENDATIONS OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION REGARDING FISCAL YEAR 1990 APPROPRIATIONS FOR PROGRAMS AUTHORIZED BY THE REHABILITATION ACT, AS AMENDED

ITEM	FISCAL YEAR 1990 RECOMMENDED APPROPRIATIONS LEVEL (in millions)
Basic State Vocational Rehabilitation Services Section 110	$1,705
State Supported Employment Services Section 638	29.73
Comprehensive State Independent Living Services Part A, Title VII	13.86
Centers for Independent Living Part B, Title VII	28.98
Independent Living Services for Older Blind Individuals Part C, Title VII	6.3
Rehabilitation Training Section 304(e)	37.0
National Institute on Disability and Rehabilitation Research Section 204	58.0
Special Demonstration Projects Several Sections in Title III	30.125
Projects With Industry Section 621	19.149
Client Assistance Programs Section 112	8.45
Special Recreation Programs Section 306	2.78
Technology	
State Demonstration Grants	**20.0**
National Projects	**6.5**

STATEMENT OF RALPH MOORE, ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES

Senator **Specter**. I would like to now call on Mr. Ralph Moore, Association for Retarded Citizens of the United States. Your full statement will be made a part of the record, Mr. Moore.

Mr. **Moore**. Thank you. I appreciate the opportunity to appear before you today on behalf of the Association for Retarded Citizens of the United States, the ARC. We have 160,000 members throughout the country, mostly parents and friends of persons with mental retardation. They represent the largest disability group in the country, persons of all ages from infants to senior citizens and all degrees of mental retardation.

The Government plays an indispensible role in meeting the very needs of that diverse group in dozens of programs. The chart at the back of our prepared statement shows our recommendations for each of these programs, most of which are under your jurisdiction and many of which are in the black box. I would like to highlight some about which we have particular concerns.

First, the preschool program for children with disabilities ages 3 to 5 and the early infant intervention program for infants and toddlers with handicaps provides services when they have the greatest impact in the handicapped child's first years. We have made great strides in preschool education for which Congress deserves applause. Comparable efforts with infants and toddlers are long overdue.

We urge Congress to keep its fiscal promise to reimburse schools for preschool programs in the full amount authorized by Public Law 99-457 of $351 million, or $1,000 per child.

We also urge Congress to fund the early infant intervention program for infants and toddlers at a level of $90 million.

Second, parents need a great deal of help understanding and dealing with the complex laws and regulations that affect disabled children, including Public Law 94-142. Parent training centers address this need, but nine States still need funding for such centers. Moreover, there is a serious shortage of teachers for children with disabilities, and other witnesses have mentioned that. We urge Congress to address these needs by funding the special education personnel development program at $95 million.

Third, our investment in the education and training of children with disabilities is being wasted by sending them home with nothing to do as they reach adulthood instead of becoming contributing members of our communities. This tragic waste of human lives is addressed by three programs of particular concern to us, among others: First, the transition program under the Education of the Handicapped Act which needs an appropriation of at least $10 million next year; second, the vocational rehabilitation State government program under the Rehabilitation Act, which we urge you to fund at its fully authorized level of $1.705 billion; and third, the support of employment State grant program under the Rehabilitation Act, which we likewise urge Congress to fund at its authorized level of $29.73 million.

PREPARED STATEMENT

I don't have time to discuss many other critically important programs on our list, but I do wish to call particular attention to the need for increased funding for the Job Training Partnership Act, the maternal and child health block grant, title XX social services block grant, and the Developmental Disabilities Act programs.

Mr. Chairman, we thank you and the members of this subcommittee for your strong support in the past and hope you will allow the expansion of these terribly important programs. Thank you.

Senator SPECTER. Thank you, Mr. Moore. We will consider your points in the full text of your statement, and we will do the best we can.

Mr. MOORE. Thank you.

[The statement follows:]

STATEMENT OF RALPH MOORE

Mr. Chairman, it is a pleasure and an honor to appear before you today on behalf of the Association for Retarded Citizens of the United States (ARC), an organization of 160,000 members throughout the country, most of them parents of children and adults with mental retardation, dedicated to the continuing task of improving the quality of life of all persons with mental retardation.

There are an estimated six million individuals with mental retardation in the United States. Mental retardation thus constitutes almost 15 percent of all persons with disabilities. There are persons with mental retardation of all ages, from infants to senior citizens. Levels of retardation vary widely, from mild retardation to severe and profound retardation. Given the diversity of the severity of the disability and that mental retardation affects persons of all ages, the needs of persons with mental retardation and their families vary greatly.

Parents of persons with mental retardation need help to maximize their child's ability to learn, to work and to live as independently as possible in their communities. Government must and does play an important role in providing education, training, housing and other vital services. There are dozens of federally supported programs which assist persons with mental retardation. I would like to call your attention to the chart at the end of our prepared statement. This chart contains our recommendations for fiscal year 1990 funding for these diverse programs, most of which are under the jurisdiction of this appropriations subcommittee. Since my time is limited, I would like to spend a couple of minutes concentrating on several very important programs. First, in the area of special education, we urge this subcommittee to give priority to increasing the appropriations to the Preschool, Early Intervention, Transition and Personnel Development Programs, as well as the Education for the Handicapped State Grant Program.

For the Preschool Program, the Congress has promised school systems a $1000 per child reimbursement in the next school year. We expect all children with disabilities from ages three through five will be receiving special education services next year. This is an outstanding achievement. The Congress and the schools are to be congratulated for authorizing and funding this critical program. We hope that Congress will live up to its fiscal promise and fully reimburse school systems as authorized by P.L. 99-457.

Equally important is the Early Infant Intervention Program to serve infants and toddlers with handicaps. This program is long overdue to begin serving children at the earliest possible age. We recommend a funding level of $90 million for this program.

It is essential that parents meaningfully participate in the development of their child's special education program. Parenting a child with mental retardation can be difficult and so is attempting to understand the several laws and regulations affecting that child's future. An important component of the Education of the Handicapped Act provides funds to operate parent training and information centers. These centers assist parents to understand their rights and responsibilities under P.L. 94-142. After training, many parents have been able to secure a better education for their child. Unfortunately, nine states do not presently have a parent training center, primarily due to funding limitations. It is important that the Congress appropriate sufficient funds in the Special Education Personnel Development Program to allow for a parent training center in each state.

Recent Department of Education statistics also indicate a 5,000 teacher shortage last year to educate children with mental retardation. Other disability groups also have significant teacher shortages as well. We want our children to be educated by qualified teachers. Our children deserve no less. These teacher shortages must be addressed immediately. We recommend the Personnel Preparation Program be funded at $95 million to address the teacher shortages and the expansion of the parent training centers.

P.L. 94-142 guaranteeing a free, appropriate education for all children with handicaps has proven to be incredibly successful. Yet, almost 70 percent of children with disabilities are doing practically nothing one year after graduating, dropping out or aging out of school. We are spending large amounts of money to educate these children but we are leaving too many to "fall between the cracks" in their adult years. Nearly all persons with mental retardation want to and can work. Yet, a recent ARC survey indicates almost 70,000 persons with mental retardation are currently on waiting lists for adult services. This is a terrible waste, both in social and economic terms. Several programs need to be expanded to better prepare these individuals for jobs. One is the Transition Program under the Education of the Handicapped Act. We spend $1.5 billion Federal dollars in special education but only $7 million to assist the more than 200,000 special education students who exit schools every year to transition into the adult world. This program needs to expand quickly and we recommend at least $10 million be appropriated next year for this program.

Two very important programs within the Rehabilitation Act also play vital roles in preparing young adults with mental retardation for work. They are the Vocational Rehabilitation State Grant Program and the Supported Employment State Grant Program. Both of these programs should be funded at their fully authorized levels of $1.705 billion and $29.73 million, respectively. This will allow for several thousand additional individuals with mental retardation to be trained to enter the work force, thus making them tax payers instead of tax users.

Mr. Chairman, since the needs of persons with mental retardation are lifelong, many other federal programs that I do not have the time to review today also need your attention and support. Very important are funding increases for the Jobs Training Partnership Act, the Maternal and Child Health Block Grant, the Title XX Social Services Block Grant and the programs within the Developmental Disabilities Act. We sincerely hope the Congress sees fit to fund these programs at the recommended amounts. Again, Mr. Chairman, we thank you and members of this Subcommittee for your strong support in the past and we hope you will again allow our programs to expand.

SUMMARY TABLE

(in millions)

	FY 1988 Appropriation	FY 1989 Appropriation	FY 1990 Authorization	President's FY 1990 Request	ARC FY 1990 Recommendation
DEVELOPMENTAL DISABILITIES PROGRAMS					
DD Basic State Grant	58.400	59.774	77.400	flex. freeze	77.400
DD Protection and Advocacy Systems	19.142	19.775	24.200	flex. freeze	24.200
DD University Affiliated Programs	12.446	12.570	16.900	flex. freeze	16.500
DD Grants of National Significance	2.872	2.901	3.650	flex. freeze	3.650
EDUCATION OF CHILDREN WITH HANDICAPS					
State and Local Grant Programs (P.L. 94-142)	1,431.737	1,475.449	formula	flex. freeze	2,201.390
Preschool Grants	201.050	247.000	formula	flex. freeze	351.000
Early Infant Intervention Program	67.010	69.830	formula	flex. freeze	90.000
Early Education for Handicapped Children	23.420	23.150	pending	flex. freeze	27.410
Secondary Education and Transitional Services	7.370	7.280	pending	flex. freeze	10.000
Postsecondary Education Programs	5.840	5.170	pending	flex. freeze	7.500
Special Education Personnel Development	66.753	67.095	pending	flex. freeze	95.000
Special Education Technology	4.696	4.730	11.025	flex. freeze	11.025
State-Operated Programs (P.L. 89-313)	151.260	148.200	formula	flex. freeze	170.000
Vocational Education	804.200	831.600	pending	flex. freeze	908.200
REHABILITATION SERVICES					
Vocational Rehabilitation State Grants	1,379.500	1,450.000	1,705.000	1,502.000	1,705.000
Supported Employment State Grants	25.935	26.900	29.730	flex. freeze	29.730
Rehabilitation Training	30.000	30.500	37.000	flex. freeze	37.000
Comprehensive State Services for Independent Living - Part A	12.310	12.678	13.860	flex. freeze	13.860
Centers for Independent Living - Part B	25.500	26.000	28.980	flex. freeze	28.980
Independent Living Services for Older Blind Individuals - Part C	5.600	5.700	6.300	flex. freeze	6.300
Protection and Advocacy - Part D	0.000	0.000	such sums	0.000	10.000
Special Demonstration Projects	27.900	28.300	30.125	flex. freeze	30.125
Special Recreational Programs	2.470	2.620	2.780	0.000	2.780
Projects with Industry	17.000	17.350	19.149	flex. freeze	19.149
Client Assistance Program	7.500	7.775	8.450	flex. freeze	8.450
National Institute on Disability and Rehabilitation Research	51.100	53.525	58.000	flex. freeze	58.000

	FY 1988 Appropriation	FY 1989 Appropriation	FY 1990 Authorization	President's FY 1990 Request	ARC FY 1990 Recommendation
			(in millions)		
BLOCK GRANT PROGRAMS					
Title XX Social Services Block Grant	2,700.000	2,700.000	2,700.000	flex. freeze	3,300.000
Maternal and Child Health Block Grant	526.570	554.000	561.000	flex. freeze	661.000
Maternal and Child Health Special Projects (SPRANS)	78.400	83.000	84.100	flex. freeze	99.100
Alcohol, Drug Abuse and Mental Health Block Grant	643.300	805.600	such sums	flex. freeze	918.600
Services to Homeless Individuals Who Are Seriously Mentally Ill	11.500	14.100	35.000	flex. freeze	100.000
PREVENTION PROGRAMS					
Women's, Infants' and Children's Supplemental Feeding Program	1,852.363	1,979.362	such sums	flex. freeze	2,058.522
Immunization Program	---	98.190	163.480	flex. freeze	102.100
Retroactive Vaccine Injury Program	(a)	101.500	such sums	flex. freeze	105.540
Pediatric AIDS -					
MCH Block Grant	4.300	7.900	---	flex. freeze	30.000
NICHD	17.100	22.000	---	flex. freeze	50.000
Abandoned Infants Assistance Act	0.000	0.000	12.000	flex. freeze	12.000
BIOMEDICAL AND BEHAVIORAL RESEARCH					
National Institute of Child Health and Human Development	396.811(b)	425.649(c)	such sums	444.193(d)	584.600
National Institute on Deafness and Other Communication Disorders	---	92.100	such sums	95.600	130.000
National Institute of Neurological Disorders and Stroke	458.792(e)	479.982(f)	such sums	501.971(g)	616.430
National Institute of Mental Health Research and Research Training					
NIMH Research	234.000	293.500	such sums	flex. freeze	500.000
NIMH Research Training	16.800	19.700	such sums	flex. freeze	44.000
SPECIAL CONCERNS					
Architectural and Transportation Barriers Compliance Board	1.890	1.890	3.000	2.000	2.200
Child Welfare Services (Title IV-B)	239.000	250.000	266.000	flex. freeze	266.000
Committee for the Purchase from the Blind and Severely Handicapped	.850	.862	such sums	flex. freeze	1.062
Comprehensive Planning for Seriously Mentally Ill Individuals	4.800	4.500	pending	0.000	10.000

	FY 1988 Appropriation	FY 1989 Appropriation	FY 1990 Authorization	President's FY 1990 Request	APC FY 1990 Recommendation
			(in millions)		
Foster Grandparent Program	53.700	58.900	pending	flex. freeze	68.140
Head Start	1,206.000	1,234.000	1,405.000	1,485.000	1,485.000
Job Training Partnership Act					
JTPA Block Grant	1,809.500	1,787.800	such sums	flex. freeze	1,881.900
JTPA Pilots and Demonstrations	39.000	30.300	such sums	flex. freeze	40.600
Legal Services Corporation	305.500	305.500	pending	0.000	393.000
Mental Health Services Demonstration	19.100	25.900	60.000(h)	flex. freeze	38.300
National Council on Disability	.892	1.160	such sums	flex. freeze	1.218
Protection and Advocacy for Persons with Mental Illness	10.555	12.400	such sums	flex. freeze	22.000
Small Business Administration - Handicapped Assistance Loan Program	13.000	12.000	23.000	0.000	23.000
Technology-Related Assistance Grants (P.L. 100-47)					
Grants to States	---	5.200	such sums	flex. freeze	20.000
National Programs	---	0.000	such sums	flex. freeze	6.500
Temporary Child Care and Crisis Nurseries for Children with Handicaps and Chronic Illnesses	4.787	5.000	pending	flex. freeze	20.000
TRANSPORTATION PROGRAMS					
Rural and Small Community Transit Grants	64.600	66.400	formula	flex. freeze	75.000
Rural Transit Assistance Program (RTAP)	4.800	5.000	5.000	flex. freeze	5.000
Urban Mass Transit Grants	1,732.300	1,603.600	formula	flex. freeze	1,669.300
Vehicle Purchase	35.000	35.000	formula	flex. freeze	56.000
HOUSING PROGRAMS					
Fair Housing Amendments Act	4.800	10.000	pending	flex. freeze	20.000
Section 202 Direct Loan Program	555.800	480.100	pending	flex. freeze	630.000
Supportive Housing Demonstration Program	64.300	80.000	105.000	105.000	105.000
Congregate Housing Services	4.200	5.400	pending	0.000	10.000
Community Development Block Grant	2,880.000	3,000.000	pending	flex. freeze	3,000.000

	FY 1988 Actual	FY 1989 Estimated	FY 1990 Proposed Budget	
			Current Law	Proposed Outlays
	(in millions)			
ENTITLEMENT PROGRAMS				
Social Security Disability Insurance	22,360.000	23,178.000	24,307.000	24,307.000
Supplemental Security Income	12,345.000	12,477.000	12,148.000	12,148.000
Medicare - Client Benefits	85,540.000	95,844.000	110,398.000	105,800.000
Medicare - Total	87,676.000	98,408.000	111,996.000	107,595.000
Medicaid - Client Benefits	29,009.000	32,543.000	35,559.000	34,459.000
Medicaid - Total	30,462.000	34,292.000	37,398.000	35,961.000
Food Stamps	12,264.000	12,867.000	12,870.000	12,710.000
Foster Care and Adoption Assistance	811.178	1,119.907	(i)	1,116.000
Adoption Assistance				

(a) Initial authorization had not occurred.
(b) Includes $17.15 million for AIDS-related research.
(c) Includes $22.0 million for AIDS-related research.
(d) Includes $27.1 million for AIDS-related research.
(e) Includes $12.3 million for AIDS-related research.
(f) Includes $13.1 million for AIDS-related research.
(g) Includes $16.4 million for AIDS-related research.
(h) The authorization for this program has been combined with the authorization for prevention, rural mental health and homeless demonstrations.
(i) The President's Budget proposes an "initiative" in the area of adoption assistance.

STATEMENT OF ROBERT LYNCH, UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

Senator SPECTER. I would like now to call on Mr. Robert Lynch, United Cerebral Palsy Associations.

Mr. LYNCH. Good afternoon, Senator.

Senator SPECTER. Good afternoon. Your full statement will be made a part of the record.

Mr. LYNCH. Thank you, Senator.

My name is Bob Lynch. I'm an architect from Pittsburgh in private practice, and I was instrumental in drafting new accessibility legislation recently signed into law in Pennsylvania. I am also a member of the Governmental Activities Committee of the United Cerebral Palsy Associations.

I would like to talk about just three programs of critical importance to individuals with severe disabilities and their families.

ASSISTIVE TECHNOLOGY

My first issue is the importance of fully funding the Technology Related Assistance for Individuals with Disabilities Act, Public Law 100–407. Last July, 8-year-old Tommy Dormer testified before Congress on the need for Public Law 100–407. Tommy was born with cerebral palsy. Without the assistance of technology, he cannot walk, talk, or write. Tommy uses a touch-activated switch near his head to operate his wheelchair, his communication device, and his computer. Tommy explained how technology changed his life and told the House Subcommittee on Select Education: "I am here on behalf of all children who need technology."

Tommy's mother also testified:

> Eight years ago when the neurologist told me my child had cerebral palsy and that he would not have total control of his body, I felt cheated. Today, with the use of computer technology, he now writes me notes and sends me letters to a favorite cousin. He tells me who his best friend is. The best thing of all is when my child who cannot talk says, "Mommy, I love you!" Tommy is capable of doing more if we could only afford to get him the equipment he needs.

Without adequate funding, children and adults with disabilities will continue to be denied access to the tools they, like Tommy, need to fully participate in society. UCPA recommends an appropriation of $20 million for fiscal year 1990.

RESPITE CARE

A critical priority for persons with disabilities and their families is family support services, including respite care. During the past 3 years, the Congress has begun to recognize the competence of families, the unique role that families play as the primary caregivers for their children with disabilities and to financially support that role rather than to supplant the family with more costly and ineffective expenditures for out-of-home care.

As Sandra Wilson, a mother in Boston, MA, succinctly said about her 6-year-old son with multiple disabilities:

> I think the hardest thing for us is the energy level it takes in managing Kevin. And I know we are not alone. If we could not get away from time to time, based on our family's schedule and needs, and obtain a competent, caring, trained respite worker, Kevin would not be in as good shape as he is physically or mentally because we wouldn't be in good shape either.

Many States have now realized the importance of family support services and respite care, but the financial incentives in most States still are in favor of out-of-home placements.

In the interest of time, I will only mention early intervention, another subject that has been treated by other people this morning. UCPA recommends an appropriation of $90 million for this important effort.

PREPARED STATEMENT

Thank you for the opportunity to present information on behalf of individuals with disabilities and their families. Please continue to give our citizens who have severe disabilities a chance to develop themselves to their fullest. Thank you for helping them to become productive citizens and fulfilled human beings who are self-reliant, happy and proud Americans.

Senator SPECTER. Thank you very much, Mr. Lynch, for your contribution, your professional time as an architect, and your study of this important problem.

Mr. LYNCH. Thank you, Senator.

[The statement follows:]

STATEMENT OF ROBERT LYNCH

My name is Bob Lynch. I am an architect in private practice and I was instrumental in drafting new accessibility legislation recently signed into law in Pennsylvania. I am also a member of the Governmental Activities Committee of United Cerebral Palsy Associations. UCPA is a national network of nearly 200 affiliates in 45 states advocating for and providing community services to persons with severe disabilities and their families. Collectively, UCPA spends over $300 million a year on a broad range of services for children and adults with severe disabilities.

I would like to talk about just a few programs of critical importance to individuals with severe disabilities and their families. Also, I would ask that the Committee support the FY 1990 budget recommendations of the Consortium for Citizens with Disabilities for all programs important to individuals with disabilities.

Assistive Technology

My first issue is the importance of fully funding the Technology Related Assistance for Individuals With Disabilities Act, P.L. 100-407. Last July, eight-year-old Tommy Dormer testified before Congress on the need for P.L. 100-407. Tommy was born with cerebral palsy. Without the assistance of technology, he cannot walk, talk or write. Tommy uses a touch-activated switch near his head to operate his wheelchair, his communication device and his computer. Tommy explained how technology changed his life and told the House Subcommittee on Select Education:

"I am here on behalf of all children who need technology."

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> "Eight years ago when the neurologist told me my child had cerebral palsy and that he would not have total control of his body, I felt cheated. Today, with the use of computer technology, he now writes me notes and letters to a favorite cousin. He tells me who his best friend is. The best thing of all is when my child who cannot talk says,

'Mommy, I love you!' Tommy is capable of doing more if we could only afford to get him the equipment he needs"

With the passage of P.L. 100-407, Congress acknowledged the powerful role that assistive technology can play in maximizing the independence and enhancing the self esteem of people with disabilities. With a relatively small amount of federal dollars this initiative is intended to leverage public and private dollars for the development in each state of a comprehensive program of technology-related assistance for individual with disabilities. Without adequate funding, children and adults with disabilities will continue to be denied access to the tools they, like Tommy, need to fully participate in society. UCPA recommends an appropriation of $20 million for FY 1990 for P.L. 100-407.

Supported Employment

For the past three years funding of, Title VI of the Rehabilitation Act, P.L. 99-506, has enabled Supported Employment programs across the country to assist individuals with cerebral palsy and other severe disabilities to become part of the work force in diverse business and industry settings. Gordon Richmond is one of the many people whose lives have been changed by this exciting approach to employment. Gordon has cerebral palsy; he is severely physically involved and has difficultly speaking. Yet his resume is dotted with honors: 1983 graduate with high honors in Business Administration, University of Alabama; Honor Scholar in Management; Most Active Jaycee. It took Gordon nearly one year after graduating from the University of Alabama to find employment with a small Huntsville computer company and that job ended after nine months due to lack of work and for want of a personal care attendant.

For the following two and a half years, Gordon actively searched for work. He wanted a job in financial management and working with computers. He turned to staff at the Department of Vocational Rehabilitation for help in finding employment, but the traditional job placement efforts proved futile. When the

UCPA Supported Employment Project began in Birmingham, Gordon was promptly referred by VR as a candidate for the program.

During an extensive job development effort which included 65 employer contacts, the Employment Specialist emphasized the potential number of ongoing services available through Supported Employment to assist a person with severe disabilities to function capably in a competitive work situation.

Gordon recently began working as an Administrative Associate at the University of Alabama School of Medicine. He is a full-time permanent employee receiving full benefits. Modification at the work site by a rehabilitation technologist and the ongoing support of a personal attendant provide the critical ingredients of this supported employment success story. UCPA recommends an appropriation of $29.73 million for Title VI of the Rehabilitation Act, an amount that will allow several thousand additional individuals with severe disabilities to benefit from supported employment programs and give them the dignity of becoming a contributing tax payer.

Respite Care

A critical priority for persons with disabilities and their families is family support services, including respite care. During the past three years, the Congress has begun to recognize the competence of families, the unique role that families play as the primary caregivers for their children with disabilities and to financially support that role rather than to supplant the family with more costly and ineffective expenditures for out-of-home care. The provision of respite care is a major step to help prevent burn-out and family disintegration. It is family-oriented, family-controlled, accessible and flexible based on the unique strengths and needs of each family. It is not crisis intervention. It is not, as Kathy Mandeville, a mother of a ten-year old son with multiple disabilities and two other children from Bedford, New Hampshire, told the House Subcommittee on Select Education, "... for families who are exhausted, unable to cope and on the brink of marital collapse, but rather it is ongoing 'preventative relief.'"

As Sandra Wilson of Boston, Massachusetts, another mother succinctly said, "I think the hardest thing for us is the energy level it takes in managing Kevin (her 6-year old son with multiple disabilities). And I know we are not alone. If we could not get away from time to time, based on our family's schedule and needs, and obtain a competent, caring, trained respite worker, Kevin would not be in as good shape as he is physically and mentally, because we wouldn't be in good shape either."

Many states have now realized the importance of family support services and respite care, but the financial incentives in most states still are in favor of out-of-home placements. In a study completed recently on state FY 88 data, by Dr. David Braddock at the University of Illinois at Chicago, State expenditures for family support services were only 1.56 percent of a total of $11.4 billion spent by state MR/DD agencies.

P.L. 100-401, the Temporary Child Care for Handicapped Children and Crisis Nurseries Act of 1986, is a vehicle for federal leadership to assist states to plan and develop a system of respite care. UCPA recommends an appropriation of $20 million for FY 1990 -- an amount consistent with the House Subcommittee's reauthorization level and an amount equal to less than 1 percent of the federal Medicaid matching funds for public and private institutions (ICFs/MR). The funding of respite care is clearly a sound investment in support of families in need across the country.

Early Intervention

In establishing Part H of the Education of the Handicapped Act, Congress recognized the extreme importance--as well as cost effectiveness--of early intervention for infants who are developmentally delayed. Four-year-old Chip Mason is a perfect example of the importance and success of the early intervention pre-school grant program. When Chip was eight months old, he was diagnosed as having cerebral palsy and significant developmental delay. He was enrolled in UCP of Central Arkansas' early intervention program when he was two. He could not stand, crawl, nor pull himself up; his primary mode of mobility was creeping.

After several months of physical, occupational and speech and language therapy, Chip began to blossom. Within a year, he was standing, weight bearing and walking with a walker. At the age of four he was able to complete the fine motor tasks and demonstrate speech and language. Chip will begin kindergarten this fall. He no longer needs to use his walker and one of his favorite recreational activities is roller skating.

As you know, the system must provide early intervention services to all eligible infants and toddlers by the end of a four-year development phase. Several state legislatures, in authorizing the program, explicitly conditioned their continued participation on receipt of federal funding at the full authorization level. To this end, UCPA recommends an appropriation of $90 million for this important program so that all infants and toddlers with disabilities can receive the intervention and family support as Chip Mason did.

Thank you for the opportunity to present information on behalf of individuals with disabilities and their families.

STATEMENT OF CAROLE ROSSICK, SELF HELP FOR THE HARD OF HEARING PEOPLE, INC.

Senator SPECTER. Now, we will call on Ms. Carole Rossick, Self Help for Hard of Hearing, Inc. Welcome. Your full statement will be made a part of the record, and you may proceed.

Ms. ROSSICK. Thank you, Senator. These are the remarks of Rocky Stone, the executive director of Self Help for Hard of Hearing People.

My name is Rocky Stone, and I am the founder and executive director of Self Help for Hard of Hearing People known as SHHH. On behalf of more than 19 million hard of hearing persons in the United States, I appreciate the opportunity to be with you today to share some concerns and recommendations related to the National Institute on Deafness and Other Communication Disorders.

We strongly support a proposed budget figure of $130 million for fiscal year 1990. We know and appreciate the severe monetary restraints under which our society must operate if we are to regain a truly healthy economy.

While historically hearing loss has affected more people in significant ways than most other limiting conditions, it has received far less attention. We have a lot of research catching up to do.

The congressional mandate for NIDCD is very broad. It provides us with an opportunity for the first time to develop both basic and applied research. We should not have to choose between the two. We should have both and in proportions that provide a large measure of early satisfaction.

The need for careful research to unravel biological and psychological complexities and to find ways to alleviate the problems which people encounter due to their hearing loss is apparent. What this means is that we need far more from NIDCD than basic medical research. We must include psychosocial factors.

NIDCD has the opportunity to draw a truly comprehensive picture of the medical approach to hearing loss with what complications of hearing loss do to the human being. Remedial directions must be based on the totality of the two. Hearing loss as a subject of medical study is only a small portion of the problem.

Today, over 17 million Americans suffer from sensorineural hearing loss. It's getting worse. As we search for cell regeneration and other hopeful cures, we must also attempt to alleviate the plight of those suffering with sensorineural hearing loss now. For them the future is today.

We have outlined our views to NIDCD in broadly stated areas and suggested both theoretical-scientific and practical approaches. For the Institute to move beyond existing projects now under way, more money is needed. Thus, we strongly support the budget figure of $130 million for fiscal year 1990, while urging NIDCD to develop a philosophy that recognizes that the whole person must be considered in the hearing health field.

PREPARED STATEMENT

Mr. Chairman, we also support specific budget figures in the areas of education, technology, and vocational rehabilitation. The amounts and rationale are included in our written testimony which has already been sent to your committee.

Thank you for this opportunity to work with you on matters of great importance to so many of us.

Senator **Specter**. Thank you very much, Ms. Rossick. We will carefully consider your intentions.

Ms. **Rossick**. I appreciate that.

[The statement follows:]

Statement of Howard E. "Rocky" Stone, Executive Director, Self Help for Hard of Hearing People, Inc. [SHHH]

Mr. Chairman and committee members, my name is Rocky Stone and I am the founder and Executive Director of Self Help for Hard of Hearing People, known as SHHH.

On behalf of more than 19 million hard of hearing persons in the United States, I appreciate the opportunity to be with you today to share some concerns and recommendations related to the National Institute on Deafness and Other Communication Disorders [NIDCD].

We strongly support a proposed budget figure of $130 million for fiscal year 1990. We know and appreciate the severe monetary restraints under which our society must operate if we are to regain a truly healthy economy.

While historically, hearing loss has affected more people in significant ways than most other limiting conditions, it has received far less attention. We have a lot of research catching up to do. The Congressional mandate for NIDCD is very broad. It provides us with an opportunity—for the first time—to develop both basic and applied research—we should not have to choose between the two; we should have both and in proportions that provide a large measure of early satisfaction.

The need for careful research to unravel biological and psychological complexities and to find ways to alleviate the problems which people encounter due to their hearing loss is apparent. What this means is that we need more from NIDCD than basic medical research. We must include psychosocial factors.

NIDCD has the opportunity to draw a truly comprehensive picture of the medical approach to hearing loss with what complications of hearing loss do to the human being. Remedial directions must be based on the totality of the two. Hearing loss as a subject of medical study is only a small portion of the problem. Today, over 17 million persons suffer from sensorineural hearing loss. It's getting worse. As we search for cell regeneration and other hopeful cures, we must also attempt to alleviate the plight of those suffering with sensorineural hearing loss now. For them, the future is today.

We have outlined our views to NIDCD in broadly stated areas and suggested both theoretical-scientific and practical approaches. For the Institute to move beyond existing projects now under way, more money is needed. Thus we strongly support the budget figure of $130 million for fiscal year 1990, while urging NIDCD to develop a philosophy that recognizes that the whole person must be considered in the hearing health field.

Mr. Chairman, we also support specific budget figures in the areas of education, technology and vocational rehabilitation. The amounts and rationale are included in our written testimony which has already been sent to your Committee.

Thank you for this opportunity to work with you on matters of great importance to so many of us.

STATEMENT OF DONNA DICKMAN, PH.D., COCHAIRPERSON OF THE COUNCIL OF ORGANIZATIONAL REPRESENTATIVES

Senator SPECTER. Now, I would like to turn to Gary Olsen and Dr. Donna Dickman, cochairs for the Council of Organizational Representatives. Your full statement will be made a part of the record, and you may proceed.

Dr. DICKMAN. Thank you very much.

My name is Donna McCord Dickman and I am the cochair of the Council of Organizational Representatives known as COR which is a coalition on public policy and other issues related to improving the quality of life for deaf and hard of hearing people as well as persons who suffer from related disorders such as tinnitus.

I am sorry that my colleague and cochair, Gary Olsen, is unable to join us today.

I am the executive director of the Alexander Graham Bell Association for the Deaf, which is one of the 12 voting member organizations representing over 100,000 persons in all 50 of the United States. Of this membership, more than two-thirds are deaf or hard of hearing people, and the other one-third are primarily parents or professionals involved in education and service provision. Many are representatives of two or more of the above categories. For example, we have deaf and/or hard of hearing parents who are also professional educators, physicians, or persons serving in related services as well. A list of the 12-member organizations of COR is attached to my testimony.

Collectively, we represent the needs and interests of a wide spectrum of well over 20 million hearing impaired people. For further background information, we have included in attachment 2 the history of the formation of COR.

COR feels that the establishment of the National Institute on Deafness and Other Communicative Disorders was a great victory for the millions of deaf and hard of hearing people served by our member organizations. As stated in our review of the Institute's national strategic research plan, which I've attached in attachment 3, our support of this Institute is unqualified.

I am here today to convey to you that the members of COR have endorsed a proposed budget figure of $130 million for the Institute for fiscal year 1990. The congressional mandate is broad and we

are anxious to see that the Institute has adequate funding to deal comprehensively with the issues of accommodation, treatment, and rehabilitation of Americans with hearing and other communicative disorders. We plan to work closely with the Institute as it begins to implement the strategic plan. A part of our effort will be to promote the incorporation of behavioral and psychosocial aspects of hearing impairment whenever and wherever appropriate.

PREPARED STATEMENT

Mr. Chairman, on behalf of our 12 voting member organizations, thank you so very much for the opportunity to communicate to the committee our support of this budget level for the Institute. I would be pleased to answer any questions that you might have.

Senator **SPECTER**. Thank you very much, Dr. Dickman. I regret that our time is so short that we are going to be foreclosed from asking questions, but we shall consider your request very carefully.

Dr. **DICKMAN**. Thank you very much.

[The statement follows:]

STATEMENT OF DONNA DICKMAN

MY NAME IS DONNA MCCORD DICKMAN AND I AM THE CO-CHAIR OF THE COUNCIL OF ORGANIZATIONAL REPRESENTATIVES (COR) WHICH IS A COALITION ON PUBLIC POLICY AND OTHER ISSUES RELATED TO IMPROVING THE QUALITY OF LIFE FOR DEAF AND HARD OF HEARING PEOPLE AS WELL AS PERSONS WHO SUFFER FROM RELATED DISORDERS SUCH AS TINNITUS. I AM JOINED TODAY BY GARY OLSEN MY FELLOW COR CO-CHAIR.

I AM THE EXECUTIVE DIRECTOR FOR ONE OF THE 12 VOTING MEMBER ORGANIZATIONS REPRESENTING OVER 100,000 PERSONS IN ALL FIFTY OF THE UNITED STATES. OF THIS MEMBERSHIP, MORE THAN TWO-THIRDS ARE DEAF OR HARD OF HEARING PEOPLE, AND THE OTHER THIRD ARE PRIMARILY PARENTS OR PROFESSIONALS INVOLVED IN EDUCATION AND SERVICE PROVISION. MANY ARE REPRESENTATIVE OF TWO OR MORE OF THE ABOVE CATEGORIES. FOR EXAMPLE, WE HAVE DEAF AND OR HARD OF HEARING PARENTS WHO ARE ALSO PROFESSIONAL EDUCATORS, PHYSICIANS OR RELATED SERVICE PROVIDERS AS WELL. A LIST OF OUR MEMBER ORGANIZATIONS IS ATTACHED TO OUR TESTIMONY (ATTACHMENT #1). COLLECTIVELY, WE REPRESENT THE NEEDS AND INTEREST OF A WIDE SPECTRUM OF APPROXIMATELY 20 MILLION HEARING-IMPAIRED PEOPLE FOR FURTHER BACKGROUND INFORMATION, ATTACHMENT #2 DESCRIBES THE HISTORY OF THE FORMATION OF COR.

COR FEELS THAT THE ESTABLISHMENT OF THE NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATIVE DISORDERS (NIDCD) WAS A GREAT VICTORY FOR THE MILLIONS OF DEAF AND HARD OF HEARING PEOPLE SERVED BY OUR MEMBER ORGANIZATIONS. AS STATED IN OUR REVIEW OF THE NIDCD'S NATIONAL STRATEGIC RESEARCH PLAN (ATTACHMENT #3), OUR SUPPORT OF THE INSTITUTE IS UNQUALIFIED.

MR. OLSEN AND I ARE HERE TODAY TO CONVEY TO YOU THAT THE MEMBERS OF COR HAVE ENDORSED A PROPOSED BUDGET FIGURE OF 130 MILLION DOLLARS FOR NIDCD FOR FY 1990. THE CONGRESSIONAL MANDATE FOR THE INSTITUTE IS BROAD AND WE ARE ANXIOUS TO SEE THE

INSTITUTE HAVE ADEQUATE FUNDING TO DEAL COMPREHENSIVELY WITH THE UNDERSTANDING, ACCOMMODATION, TREATMENT AND REHABILITATION OF AMERICANS WITH HEARING AND OTHER COMMUNICATION DISORDERS. OUR COR MEMBERSHIP PLANS TO WORK CLOSELY WITH THE INSTITUTE AS IT BEGINS TO IMPLEMENT THE NATIONAL STRATEGIC RESEARCH PLAN. A PART OF OUR COOPERATIVE EFFORT WILL BE TO PROMOTE THE INCORPORATION OF BEHAVIORAL AND PSYCHOL SOCIAL ASPECTS OF HEARING IMPAIRED WHENEVER AND WHEREVER APPROPRIATE.

MR. CHAIRMAN, ON BEHALF OF OUR TWELVE VOTING MEMBER ORGANIZATIONS, THANK YOU FOR THE OPPORTUNITY TO COMMUNICATE TO THE COMMITTEE OUR SUPPORT OF THE PROFESSIONAL JUDGEMENT BUDGET FOR NIDCD. MR. OLSEN AND I WOULD BE PLEASED TO RESPOND TO ANY QUESTIONS AT THE APPROPRIATE TIME.

ATTACHMENT 1

COUNCIL OF ORGANIZATIONAL REPRESENTATIVES
MEMBERSHIP

Alexander Graham Bell Association for the Deaf
American Academy of Otolaryngology-Head and Neck Surgery, Inc.
American Deafness & Rehabilitation Association
American Society for Deaf Children
American Tinnitus Association
Convention of American Instructors of the Deaf
Conference of Educational Admin. Serving the Deaf
Deafness Research Foundation
National Association of the Deaf
National Fraternal Society of the Deaf
Self Help for Hard of Hearing People
Telecommunications for the Deaf, Inc.

Corporate Member: Corporate Services for the Deaf, Incorporated

ATTACHMENT #2

COR HISTORY

In 1980, Dr. T. Alan Hurwitz and Dr. William E. Castle became presidents-elect for the National Association of the Deaf (NAD) and the Alexander Graham Bell Association for the Deaf (AGBAD), respectively. During the two years that followed they conferred with one another with some frequency about the ways in which the two organizations might work more closely together and enlist the interest of other organizations of and for the deaf to do the same.

On June 25, 1982, when Dr. Castle presented his inaugural speech at the Toronto convention of AGBAD, the speech was entitled "Working Together/Tous Ensemble; Building Networks for Progress". Within that speech Dr. Castle pointed out that " ...The Alexander Graham Bell Association for the Deaf (AGBAD) does not exist in a vacuum; it is an organization among organizations, all of which serve the interest of deaf people... All such organizations and agencies exist because they stand for different and special purposes; and some of the differences, of course, are philosophical. However, differences in philosophy need not disappear in order for them to become less of an obstacle to cooperation among organizations."

In early July of 1982, at the NAD convention in St. Louis, Missouri, Dr. Hurwitz presented his inaugural speech, which was entitled "Reflections: Past, Present, and Future Outlook." Within that speech, Dr. Hurwitz said, "...We must develop stronger working relationships with other national organizations which serve the needs of deaf people and other disabled people. We cannot afford to function alone. Our number is too small to have sufficient clout on political and legislative matters.

Government officials and politicians tend to shy away from us when there is infighting among us. We have more to lose by splitting among ourselves. True, we have differences and are unique in our own ways, but there is a great deal of common ground for all of us to work together."

As president of AGBAD, Dr. Castle served also as a member of the Council on Education of the Deaf. At a meeting of the Council in the latter part of 1982, Mr. Bill Peck, president of the Conference of Educational Administrators Serving the Deaf (CEASD) indicated that he agreed with the "togetherness" thesis emphasized in Dr. Castle's inaugural speech in Toronto and recommended that CED consider full support of the thesis. It was agreed at that meeting that Dr. Castle should assume an initiative to work on behalf of CED in conjunction with NAD to promote the thesis. As it turned out, CED and NAD, through their respective presidents decided to co-host a special mini-conference which had as its theme "Working Together on Legislative Goals Regarding Deafness."

An initial planning meeting for the mini-conference was held at the NAD headquarters on November 30, 1982. Involved in this planning meeting were the presidents of NAD and AGBAD and the executive directors of the American Deafness and Rehabilitation Association (ADARA), AGBAD, the Convention of American Instructors of the Deaf (CAID), CEASD, the International Association of Parents of the Deaf (IAPD; now know as the American Society for Deaf Children), NAD, the Registry of Interpreters for the Deaf (RID), and Telecommunications for the Deaf, Incorporated (TDI).

The mini-conference was held on the campus of Gallaudet University (then known as Gallaudet College) on January 14-15, 1983. It was a conference with no budget; all participants came at their own expense or at the expense of their organization. Fifty-four people were invited to attend and forty-three did so including Patria Forsythe as the first speaker.

The conferees voted unanimously for some kind of legislative coalition to be put in place. On february 15 a meeting, chaired by Dr. Castle, was held among the respective executive directors, ADARA, CAID, CEASD, IAPD, NAD, RID, and TDI. It was called a meeting of the Interim Council of Executive Directors and Dr. Hugh Summers, executive director of CEASD/CAID was chosen as chairman.

The Interim Council called for another meeting on February 22 at that meeting it was agreed that an informal Council of Organizational Representatives should be established, which would be made up of the executive directors of ADARA, AGBAD, CAID, CEASD, IAPD, NAD, RID, and TDI, the president of the American Association of the Deaf Blind (AADB) and a Washington, DC based designee of the National Fraternal Society for the Deaf (NFSD).

This Council of Organizational Representatives has been meeting regularly on a monthly basis since the first meeting in February, 1983. Its agenda have been very diverse but always on. target; and very recently the number of member organizations has increased from ten to twelve and there has been a move on to make to organization more formal and more proactive than reactive. The Registry of Interpreters for the deaf has resigned as a member organization but the following organizations have become members: a) the Academy of Otolaryngology (AO), the Deafness Research Foundation (DFR), Self Help for the Hard of Hearing People (SHHH) and American Tinnitus Foundation.

ATTACHMENT #3

April 18, 1989

Mr. Sean Donohue
National Institutes of Health
Shannon Building, Room 218
9000 Rockville Pike
Bethesda, MD 20892

Dear Mr. Donohue:

This letter serves as a brief summary statement by the Council of Organizational Representatives (COR) to the National Strategic Research Plan prepared by the NIDCD's Task Force.

COR, by way of brief comment, is a coalition of organizations on public policy and other issues related to improving the quality of life for deaf and hard of hearing people. Our membership includes the following eleven organizations:

- Alexander Graham Bell Association for the Deaf
- American Academy of Otolaryngology-Head and Neck Surgery, Inc.
- American Deafness & Rehabilitation Association
- American Society for Deaf Children
- Convention of American Instructors of the Deaf
- Conference of Educational Administrators Serving the Deaf
- Deafness Research Foundation
- National Association of the Deaf
- National Fraternal Society of the Deaf
- Self Help for Hard of Hearing People
- Telecommunications for the Deaf, Inc.

COR feels the establishment of NIDCD was a great victory for the millions of deaf and hard of hearing people represented and served by our member organizations. But the victory in the battle to establish this new institute has not ended the war to improve the lives of current and future generations of Americans. Much remains to be done.

NIDCD represents a historic opportunity for progress. The Task Force Report indicates a broad range of areas for effective action, and COR fully supports them. However, we want also to ensure and to be assured the NIDCD will have appropriate concern with the behavioral and psychosocial aspects of deafness and hearing loss. This concern was not as obvious in the Task Force Report as some of our member organizations had hoped and expected it to be.

COR's support for the establishment of NIDCD is unqualified. We consider ourselves in common cause and expect to create a partnership with the Institute to address all aspects of deafness and hearing impairment. As a function of this partnership, we ask that every possible step be taken to ensure that a concern for the behavioral and psychosocial aspects of hearing impairment be made an integral part of NIDCD structure and operations.

Our member organizations can individually provide definition as to how this can best be achieved. Clearly, this request is a challenge and a mandate to make NIDCD the best it can be: an institute which comprehensively deals with the understanding, accommodation, treatment and rehabilitation of Americans with hearing and other communication disorders. We trust and hope that this goal is the vision of all who have been associated with NIDCD, and offer the services of COR and our individual member organizations in achieving it.

Sincerely,

Donna M. Dickman

Gary W. Olsen
Co-Chair

Donna M. Dickman
Co-Chair

STATEMENT OF SUSAN SCOTT, NATIONAL REHABILITATION CAUCUS

Senator SPECTER. I would like now to call on Ms. Susan Scott, National Rehabilitation Caucus. Your full statement will be made a part of the record, and you may proceed.

Ms. SCOTT. Thank you, Senator, because I am presenting a much abbreviated form this morning. So, I ask that my full statement be made part of the record.

Senator SPECTER. Yes; it will be.

Ms. SCOTT. The purpose of my testimony today is to urge the subcommittee's support for appropriations necessary to fund several programs enacted by Congress last year, specifically legislation authorizing the health professions training authorities contained in title VII of the Public Health Service Act. These programs include modest but critically important initiatives to begin alleviating the severe shortage of allied health professionals throughout the Nation.

Hospitals, nursing homes, home health agencies, rehabilitation facilities, school systems, and other service providers are simply unable to recruit sufficient numbers of qualified personnel to provide these services. This manpower deficit is approaching crisis proportions, particularly with respect to rehabilitation professionals whose skills and services are so important in the provision of care to the elderly, the chronically ill, handicapped children, and the mentally retarded. These shortages will intensify in the years ahead unless there is a renewed effort to assure the availability of an adequate number of practitioners.

A number of studies, surveys, and reports underscore the shortage of allied health personnel and the worsening outlook on the horizon. Among the fields experiencing the most acute shortages are occupational therapy, physical therapy, speech-language pathology, and audiology and respiratory therapy.

These shortages are a result of a combination of factors including a surge in demand for services from a population in which more individuals survive into old age often with chronic conditions or multiple disabilities. In addition, medical and technological advancements have increased the frequency of survival from accidental trauma or severely disabling conditions present at birth heightening the demand for a range of services to enhance functional independence and quality of life.

The capacity of our educational institutions has been insufficient to meet this rising demand. The system lacks resources to expand existing programs or create new ones. There is also a shortage of faculty and our ability to recruit students has been hampered by the fact that Federal support for education has declined dramatically over the past 8 years.

The legislation adopted last year created three initiatives to begin addressing this problem. Specifically, under section 796 of title VII, it created an allied health projects and grants provision through which the Secretary may fund the development and expansion of allied health faculty and program resources and to assist in the recruitment of individuals in the allied health professions. This section would authorize at a level of $2 million for fiscal year 1990.

Section 797 of title VII authorizes funding for development and operation of programs to train faculty.

Finally, section 751 of title VII authorizes the creation of a loan repayment program to attract key allied health personnel to rural and underserved areas throughout the Nation. Again, this initiative was authorized for fiscal year 1990 at the $2 million level.

PREPARED STATEMENT

The National Rehabilitation Caucus views all of these provisions as extremely important steps in what must be an aggressive public and private sector effort to combat these shortages. We respectfully urge the subcommittee to support full funding of the fiscal year 1990 authorization levels in each of these areas.

Thank you, Senator, for the opportunity to appear.

Senator SPECTER. Thank you very much. We will consider your testimony very carefully.

[The statement follows:]

STATEMENT OF SUSAN SCOTT

EXECUTIVE SUMMARY

Today, medical and community-based rehabilitation facilities are finding it increasingly difficult to recruit and retain sufficient numbers of qualified rehabilitation professionals to treat their patients and clients. The most severe shortages are of occupational therapists, physical therapists, speech-language pathologists and audiologists and respiratory therapists.

The 100th Congress recently enacted the "Health Omnibus Programs and Extension Act of 1988", P.L. 100-607, which contains two provisions that would make available in each of FYs 90 and 91 $2 million each for faculty and program strengthening and for traineeships for advanced training of allied health professionals, including rehabilitation therapists. However, these funding levels are grossly inadequate to meet the present rehabilitation needs of the nation's elderly and disabled individuals.

The need for these professionals far exceeds the supply in all but a few places in the country. This shortage will become more severe in the future as the numbers of the elderly increase and advances in technology save and prolong life. In fact, Hospitals recently reported that:

> "The nurse shortage crisis has affected the quality of direct patient care, and its causes and implications have been well documented. But another crisis is imminent: a shortage of allied health workers. And until a solution to the problem is found, a wide range of hospital services will be affected. In fact, a recent study from the Institute of Medicine (IOM), Washington, D.C., projects that by the year 2000, the demand for physical therapists will increase by 87 percent... and occupational therapists, 52 percent." (November 5, 1988).

Something must be done to increase the number of rehabilitation therapists in the workforce. Simply put, existing educational programs for rehabilitation professionals cannot meet the current demands or increase the numbers of graduates to meet these needs. This is due to lack of funding for program development or expansion, inadequate supply of faculty and little or no funds for scholarships or loans to attract students into the programs, including minority students.

Thus, the National Rehabilitation Caucus representing medical and community-based rehabilitation therapists and facilities recommend that the 101st Congress support full funding of the FY 1990 authorization levels approved in P.L. 100-607 for rehabilitation personnel faculty and program development, traineeships for advanced training and a new loan repayment program.

I. INTRODUCTION

Mr. Chairman:

Over the last few years, medical and community-based rehabilitation facilities have been experiencing problems in recruiting and retaining qualified rehabilitation professionals to treat patients and clients. The primary areas of concern are with the numbers of physical therapists and occupational therapists. Facilities have resorted to bonuses, career ladders, flexible schedules and hours, paying child care expenses, continuing education, and other strategies to retain hard won therapists. Two new companies were created over the last two years solely to help recruit qualified therapists from abroad. Yet even these innovative measures have not alleviated the shortages.

The National Easter Seal Society's recently published monograph on "Recruitment and Retention of Rehabilitation Professionals in the Nineties and Beyond," which explores the dimensions of the shortage of rehabilitation professionals, similarly notes that "society faces a diminishing pool of physical and occupational therapists, speech-language pathologists, and nurses", and "such shortages are both significant and growing." Further, a report released in the Fall of 1988 by the Institute of Medicine, a division of the National Academy of Sciences, declared that unless policymakers intervene, the health care industry will suffer from a "serious shortage of allied health professionals". Specifically, the IOM pointed out that the most serious shortage by the year 2000 could occur in the fields of physical and occupational therapy. Finally, at a recent meeting, the Prospective Payment Assessment Commission (ProPAC), revealed results of a 1988 study its staff conducted on personnel shortages in hospitals. ProPAC reported that in addition to the nursing shortage, "there is also a shortage in some allied health areas such as physical therapists (and) occupational therapists."

II. PUBLIC LAW 100-607: MODEST RELIEF AT BEST

The 100th Congress recently enacted the "Health Omnibus Programs and Extension Act of 1988", P.L. 100-607. Title VI of that Act, the Health Professions Reauthorization Act of 1988, originally was introduced as legislation (S. 2229, H.R. 4983) to reauthorize Title VII of the Public Health Service Act. Congress, in its last few days, combined these and other health bills into one extensive omnibus bill. Unfortunately, not all the original language and provisions in S.2229 concerning allied health professionals in general and rehabilitation therapists in particular were adopted.

Specifically, P.L. 100-607 does provide for:

A. $2 million in each of FYs 1990 and 1991 for allied health project grants and contracts--(Section 624). This Section makes available at the discretion of the Secretary of HHS, funds for faculty strengthening. In addition, funds will be provided for "improving and expanding program enrollments in those professions in greatest demand and whose services are most needed by the elderly," and "training programs that promote the effectiveness of allied health practitioners in geriatric assessment and the rehabilitation of the elderly";

B. $2 million for each of FYs 1990 and 1991 for traineeships for advanced training of allied health personnel--(Section 625). This will help faculty shortages by providing some funding to "plan, develop, establish, expand and operate doctoral programs for the advanced specialty training of allied health professionals". The Secretary of HHS must limit these discretionary grants and contracts to those allied health fields that have the most "significant shortages" of practitioners and which have a "significant role in the care and rehabilitation of patients who are elderly or disabled";

C. $2 million in each of FYs 1989-91 for a loan repayment program for allied health personnel--(Section 604).

The Secretary of HHS also must submit a report to Congress in 18 months containing information and analysis of assessments of "health manpower" shortages.

While this law does provide an important first step to help alleviate the shortage of rehabilitation professionals, the funds authorized are insufficient when compared with what is actually required. As well, no funds are authorized by P.L. 100-607 for entry level allied health students' assistance.

III. CONCLUSION

The educational system for the rehabilitation professions has not been able to meet the demand for core rehabilitation therapists. This inability to produce enough therapists is caused by:

- Inability to increase class sizes for lack of funds
- Inadequate number of educators in these professions
- Shortage of programs nationwide in certain professions
- Decreasing funds for scholarships and loans to attract students into these programs.

The National Rehabilitation Caucus urges that the 101st Congress appropriate funds for a substantial grant program to fund the expansion or development of new programs, increase the number of qualified faculty and attract students into these critical rehabilitation fields.

IV. RECOMMENDATIONS

Given the extreme shortages of occupational therapists, physical therapists, speech-language pathologists and audiologists and respiratory therapists, the National Rehabilitation Caucus urges the Appropriations Committee to support full funding of the FY 1990 authorization levels contained in the following sections of Title VI of the Health Omnibus Programs and Extension Act of 1988 (P.L. 100-607):

- Section 604, Loan Repayment Program for Allied Health Personnel, $2 million [Section 751 of Title VII, the Public Health Service Act];

- Section 624, Allied Health Project Grants and Contracts, $2 million [Section 751 of Title VII, the Public Health Service Act];

- Section 625, Traineeships for Advanced Training of Allied Health Personnel, $2 million [Section 797 Title VII, the Public Health Service Act].

The NRC also urges the Appropriations Committee to incorporate in its Committee report language to require the Secretary of HHS to provide grants for and enter into contracts with schools of physical therapy and occupational therapy under Title VI, Sections 624 and 625 of P.L. 100-607.

STATEMENT OF JUNE LEFFLER, NATIONAL CAPTIONING INSTITUTE

Senator **SPECTER**. I will turn to Ms. June Leffler, National Captioning Institute. Your full statement will be made a part of the record, and you may proceed.

Ms. **LEFFLER**. Good afternoon, Senator.

You have heard a lot of written testimony today, and on behalf of the National Captioning Institute and my own deaf children, I would like to give you personal testimony about the very most important piece of equipment that has come through our front door and that gives my children volumes of information they would normally have missed, and that is the television decoder.

Nine years ago when my boys wanted to watch a television program that was captioned, they would get to watch a program on Monday. There wouldn't be anything else available until Friday. Now, thanks to the Federal grants and through the National Captioning Institute's getting the private sector to caption programs, there are hundreds of hours a week available which includes most of the prime time. Thanks to Federal grants, all of the news programs, ABC, NBC, CBS, all of the PBS children's programs are now close captioned.

For the first year my son, Andrew, is 18 and he could vote in an election. He is right here at Gallaudet University. Imagine living in Washington and not being able to understand our election. The Federal Government provided the funds to caption debates and the election returns.

I found out that our youngest son, who is deaf, was a Democrat and our eldest was a Republican when I was watching them sign. And it wasn't just that they wanted to be different from each other. They were talking issues. One was talking social issues; Andrew, the Republican, was talking defense issues. It is a very special moment for our family.

The Olympics were captioned. When we think about sports and Olympics, we are talking about learning about the cultures of those countries now.

And to be a good student, to mainstream as a hearing impaired student, you have to have the same access to television information your hearing peers have. So, learning does not stop at 3 o'clock when the classroom door opens, summer vacations.

Movie classics. My children watched White Christmas every single year. This year it was captioned. It's an old movie. I heard laughter. I've never heard laughter when they watched that. I'm watching their faces as much as they watch television programming for comprehension.

NCI recognizes how many children still need equipment who cannot afford it. My children's friends come over to play, but they don't play. They want to watch television. One little boy pointed out a decoder in our family room and then the one in our den to his mother who picked him up and just signed "not fair."

The National Captioning Institute this week, Tuesday, coordinated with the Coca Cola Corp., gave out 750 decoders to financially disadvantaged deaf children. I have started a program with NCI's support called lotteries to learning where deaf children win education through donated decoders. Working with Lions Clubs, the programs are in New York, Brooklyn, Bronx, Buffalo, and Florida. We're starting one up in Philadelphia, PA. By Christmas, every child that needs it in the State of Nevada is going to have that equipment, thanks to the private sector.

PREPARED STATEMENT

And just letters. Every letter we get from those families that receive these decoders, especially the Spanish families, said the entire family is learning English. I think that says a lot. One little girl wrote a simple sentence. "We had a television. It sat on a table. Now it works." I think all the kids that are hearing impaired deserve working televisions.

Thank you very much for your support of the caption service.

Senator SPECTER. That is very impressive, Ms. Leffler. Thank you for your good work.

[The statement follows:]

STATEMENT OF JUNE LEFFLER

The National Captioning Institute (NCI) appreciates this opportunity to submit testimony in support of the FY 1990 budget needs of the Media Services and Adaptation Branch of the U.S. Department of Education. NCI is a Section 501 (c) (3) nonprofit organization established with Federal funding and now in its tenth year of operation. NCI provides television captioning services for hearing-impaired persons through a combination of both public and private sector support. In addition, NCI promotes the Line 21 closed captioned television service, and strives to ensure that all who could benefit from the service are given the opportunity to do so. The Line 21 technology is the defacto standard in North America for the delivery of captions. It is fully compatible with the television standards common to broadcasters, cablecasters, and the home video industry. The service requires the viewer to purchase a "decoder" and attach it to his or her TV set in order to see the captions.

One year ago, the Commission on Education of the Deaf reported to Congress that captioned television is a vital aspect of the daily lives of hearing-impaired Americans, should be expanded to include all television programming, and be available to all hearing-handicapped citizens. Inherent in the Commission's report and its recommendations was the need for a greater Federal role in establishing an affirmative action plan that would lead to more widespread captioning of broadcast and cablecast TV programs, as well as those video materials produced with Federal funds, including those presented in public places. Additionally, the Commission stressed the need for the availability of TV sets with caption decoding circuitry built in by the TV set manufacturer. The following letter received by NCI from the parent of a deaf youngster amplifies the Commission's recommendation relative to captioning:

> *"The point I wish to make is that he would never have been able to accomplish these things without a good understanding of the structure and use of the English language.*
>
> *My wife and I believe that the availability of closed captioning for the deaf has played a key role in helping our son develop his language skills and realize his true potential.*
>
> *As a family closed captioning has helped us to communicate with one another, to share ideas and understandings as well as facts and information. This in turn has helped immeasurably in our son's growth as a mature, responsible young adult."*

The Federal government has taken some initial steps recommended by the Commission; since NCI testified last year there have been encouraging developments in the amount and diversity of captioned programs; the availability of decoders; and the participation of the private sector in the provision of the service. It is also worthy of note that the House of Representatives has modified its rules to allow captioning of its televised proceedings. In addition, legislation has been introduced in the Senate that would provide captioning of that body's activities. NCI has obtained the cooperation of C-Span in planning for future captioning, and hopefully, these events will rapidly lead to accessibility of these proceedings by the hearing-impaired community. Despite these promising notes, however, on-going Federal support of the captioning service is needed to assist in fulfilling the recommendations of the Commission.

CAPTIONED PROGRAM DEVELOPMENTS: CONTINUING THE PUBLIC / PRIVATE SUPPORT PARTNERSHIP

The number of hours of closed-captioned programming available on broadcast TV, cable TV, and home video has increased dramatically in the last year. These increases have resulted in large part from increased funding from the Department of Education, which has had a multiplying effect on matched funding from the private sector.

All three major commercial television networks and the Public Broadcasting Service continue their commitment of supporting captioning costs. As a result, almost 95% of all prime time programming on the networks is now captioned, a significant increase over the 66% of just two years ago. In addition, many PBS adult and children's programs are captioned.

Television program syndicators have also begun to pay for the captioning of their shows. Most notably, WHEEL OF FORTUNE, JEOPARDY, and THE OPRAH WINFREY SHOW continue to be captioned with full private sector support. NCI secured private sector funding to caption both the Winter and Summer Olympics in 1988, a total private sector funding commitment resulting in nearly 300 hours of captioned Olympics coverage. NCI's Cable Captioning Consortium involves seven leading basic cable networks and fifteen of the top Multiple System Operators. Launched in 1988, the Consortium has made possible the captioning of over 100 hours of programming on basic cable, ranging from sports and drama to music and cartoons.

Two new initiatives of the Department of Education are partially responsible for the increase in the number and diversity of captioned programs available to hearing-impaired Americans. One initiative provides funding for captioning of all major sporting events televised by the networks and basic cable systems; a second initiative provided funding for the captioning of prime time movies, mini-series, specials and, for the first time, daytime dramas. Elderly hearing-impaired persons who are home during the day will now be able to enjoy a significant amount of daytime television.

Captioned news and public affairs programming has increased dramatically over the past two years. Since January 1988, DOED grant funding has allowed NCI to simultaneously caption all three network weeknight evening news broadcasts for the first time. Shared funding arrangements with CBS allows NCI to caption that network's weekend news program as well as 48 HOURS and WEST 57th STREET.

Other funding from DOED enables NCI to caption many children's TV programs, including SESAME STREET, MR. ROGERS' NEIGHBORHOOD, and many other PBS, commercial network, and syndicated programs.

Another area of growth has been in the captioning of local news broadcasts. There are 39 stations across the country currently providing this service with a total market penetration of 45 million homes, or approximately half the TV households in the United States. With the assistance of DOED grant funds, additional stations will be starting local captioning in 1989. In each case, Federal funds are to be matched with private sector funds, and at the expiration of these three-year grants, the local station will be responsible for finding ongoing private support for the service.

NCI believes that the private sector must steadily increase its commitment to the captioning service, and toward that end, NCI has been successful in developing and maintaining cooperative relationships with networks, producers, syndicators, cable operators, home video companies and advertisers to expand the closed-captioning service. The approach NCI has taken for each of the Federal initiatives described above has resulted in commitments from major private-sector companies that supplement the Federal funding, allowing NCI to increase significantly the volume of captioned programming that would be made available with Federal funds alone. As an example, in the 1988-1989 television season at least 42 hours per week of captioned programs on the networks and in syndication are funded with combined private/public sector funds, with the private sector commitment totaling over $1.2 million.

FUNDING RECOMMENDATIONS

The current three-year grant initiatives in the areas of national news, children's programming and syndication are entering their final year of funding. It is vital that these activities continue, thus allowing hearing-impaired Americans access to these important segments of televised education, information, and entertainment. Continued Federal support should also be used to leverage the private sector to steadily increase its commitment to captioning. NCI also recommends continued funding of current programming initiatives in the areas of sports, local news captioning, and movies.

Specific captioning program funding levels recommended for FY 1990 are as follows:

National News	—	$2.5 million
Children's Programming	—	$1 million
Syndicated Programming	—	$1 million
Sports Programming	—	$0.5 million
Movies & Daytime	—	$1 million
Local News	—	$1 million
TOTAL		$7 million

This recommended funding level for captioned programming would allow for a modest increase in support for the vital area of captioned national news programming, as well as a small increase in start-up funds to initiate captioning of local news programming. This latter funding assistance will encourage local TV stations to investigate and implement new technologies such as electronic newsroom captioning that can provide captioning services at little or no on-going cost to the TV station. NCI believes that with a sustained effort, this initiative would lead to captioning of local news programs in virtually every TV market within a few years.

DECODER DISTRIBUTION DEVELOPMENTS

Federal support of decoder development and subsidy has enabled NCI to continue producing a consumer product that is ever-more affordable to hearing-impaired families. As a result of this, the audience receiving the captioning service continues to grow. The funding that Congress appropriated in FY 1987 resulted in the development of a smaller, lower cost decoder, the TeleCaption 3000, that became available for retail purchase for an estimated $180 in June 1988. The TeleCaption 3000 has been an enormous success, with 1988 sales of caption decoders doubling the 1987 sales level. This increased interest in captioned television has continued into 1989 as well. To meet the consumer demand for less costly decoders with enhanced features, NCI has developed a new TeleCaption 4000 decoder which, with continued Federal subsidy applied, will have a final cost to the consumer of an estimated $165. TeleCaption 4000 will provide a purchase oppertunity for many individuals who could not afford previous models; its cost will be 42% less than the original decoder model which was introduced ten years ago. Continued Federal support of the decoder program will ensure that affordable decoders continue to be available to all hearing-impaired consumers.

In response to the recommendation from the Commission on Education of the Deaf, NCI has begun development of the technology which will lead to a lower-priced and multi-purpose single captioning chip being manufactured. (The chip would be the internal piece of hardware circuitry that "decodes" the captions.) Such a chip could be built into TV sets at a very small incremental cost to the consumer. This same chip could be built into other products, such as a lower priced external decoder, a tunerless decoder (for VCR/cable converter applications), and into VCRs also. The attached resolution of NCI's Corporate Advisory Council is evidence of the broad support that this concept has within corporate America. The promise of this breakthrough is clear — widespread availability of the captioning service at nominal cost to the consumer. NCI anticipates that by 1991 televisions will have such a capability. However, there continues to be a need to provide low-cost decoders to hearing-impaired persons who may not have the economic means to purchase a decoder or a new television receiver. For that reason, Federal support should continue to be extended for the existing decoder subsidy program.

As NCI continues to improve captioning technology, it is also monitoring the development of High Definition Television (HDTV). This will assist in captioning being an integral part of the development of that technological advancement.

FUNDING RECOMMENDATIONS

NCI recommends that the Federal government continue to fund decoder subsidy activities at an annual level of $1 million.

OTHER ACTIVITIES

Public Awareness and Public Education

NCI urges that a more aggressive program be initiated with Federal support to ensure that the many persons in the United States who could benefit from the captioning service are made aware of the availability of captioned TV programs and the decoder device. Among the populations which should be targeted are the elderly, persons with reading and learning problems, and persons learning English as a second language.

In addition, specific activities should be focused towards the television industry to make its leaders aware of emerging technologies which can make the provision of captioning services less costly to initiate and maintain. In addition, the TV industry needs to be made aware of the large segments of their audiences which can benefit from the captioning service.

Ongoing Research

Over the past nine years, NCI has initiated several research studies into the effectiveness of captioned television as an educational tool. NCI believes that Federal support for wide-ranging additional research into caption readability and the measurement of its effect on the acquisition of reading skills is desirable and necessary. With the audience for the captioning service steadily increasing, and the availability of increased captioned programming for children, additional research should be undertaken that will lead to improved captioning standards and techniques.

FUNDING RECOMMENDATIONS

An aggressive public awareness and public education initiative designed to reach those potential audiences that are as yet untapped beneficiaries of the captioning service should be funded at the $ 1 million level. On-going research into caption readability and the effect of captioning on reading should be funded at the $0.5 million level.

SUMMARY OF RECOMMENDED FY 1990 FUNDING LEVELS

National and Local Captioned Programming -	$ 7.0 million
Decoder Subsidy Program -	$ 1.0 million
Public Awareness and Education -	$ 1.0 million
Research -	$ 0.5 million
TOTAL	$ 9.5 million

NCI recognizes that the economic times we are living in require moderation in the hopes and aspirations placed on Federal resources. Therefore, these FY 1990 recommended levels approximate the appropriated levels for these activities during FY 1989.

NCI believes the above are critical funding areas that fit the leadership role that Congress has played in the development and growth of the closed captioned television service.NCI wishes to express its sincere appreciation for the confidence that Congress and the Department of Education have shown in giving NCI such a crucial role to play in the development of so vital a service for so many previously ignored hearing-impaired persons.

Thank you for this opportunity to submit this testimony.

STATEMENT OF ALAN BROWNSTEIN, EXECUTIVE DIRECTOR, NATIONAL HEMOPHILIA FOUNDATION

Senator **SPECTER**. Our final witness is Mr. Alan Brownstein, executive director of the National Hemophilia Foundation.

Mr. Brownstein, you may have noted the scarcity of the audience. As the 27th witness, there are fewer here than were present at the time the first witness testified. I will take just 20 seconds to recount a short apocryphal story about the speaker who was on a long list of speakers, and it was after midnight when he was finally called and one person remained in the audience. He said I want to thank you very much for staying. The man said I didn't stay to hear you. I'm the next speaker. [Laughter.]

Senator **SPECTER**. So, it is your turn.

Mr. **BROWNSTEIN**. Well, thank you, Senator, and I won't say that.

Senator **SPECTER**. Your full statement will be made a part of the record.

Mr. **BROWNSTEIN**. Thank you.

I am Alan Brownstein. I'm the executive director of the National Hemophilia Foundation, and the National Hemophilia Foundation is a voluntary health agency working to improve the health and welfare of 20,000 people with hemophilia, von Willebrand's disease, and other deficiencies. Now, the hemophilia population is traumatized by AIDS and HIV infection because of their dependence upon blood products.

The National Hemophilia Foundation has three priority recommendations for the fiscal year 1900 appropriations affecting hemophilia and AIDS.

First, we urge that the current level of support be maintained for the hemophilia treatment centers at $4.9 million through the maternal and child health set-aside.

Second, we request that within the increased funding for AIDS research, that $3 million be provided through NIAID to expand AIDS clinical trials through the comprehensive hemophilia treatment centers which you have created.

And then thanks to your support and that of NIAID, a clinical trial with AZT in the hemophilia population has been very successful and has been initiated in over 70 hemophilia treatment centers throughout the United States. This concept needs to be expanded to open up other NIAID supported clinical trials to the hemophilia population.

In addition to expanding experimental treatment options for hemophilia, we have proven our capacity to provide excellent data through this treatment center network.

Our third request is for hemophilia AIDS education and risk reduction and pediatric AIDS support; 15 to 20 percent of sexual partners have been exposed to HIV. For this reason, in January 1989, the Office of Maternal and Child Health and the CDC established a national goal for the hemophilia community to prevent new cases of HIV infection in sexual partners and offspring of persons with hemophilia.

Senator **Specter**. Where do you get the statistic that is that high?

Mr. **Brownstein**. These are through studies that are being conducted by the CDC and the National Hemophilia Foundation. We are doing surveillance of people with hemophilia and their spouses throughout the United States. We find that this varies from place to place. The key is really to provide the kind of interventions that encourage behavior change. We have been able to successfully transfer the knowledge to provide the knowledge to the people who are affected by hemophilia.

Senator **Specter**. Did you say one out of five sexual partners is afflicted with——

Mr. **Brownstein**. HIV. That is correct. And that is why we feel a profound sense of urgency.

Senator **Specter**. When you say one out of five sexual partners, that is of the population at large?

Mr. **Brownstein**. That's in the hemophilia population and their wives. In fact, in Pennsylvania, sir, that is where the excellent studies were done in Hershey and in Pittsburgh where the figures were quite higher and that is what created the alarm nationwide that we needed to do something about this.

I'm red.

Senator SPECTER. Take another minute or 2, whatever you need. When I say take another minute, or 2, or 3, then you have full time again. It is sort of ridiculous to ask you all to testify in 3 minutes, but that is the rule which has been established long before my time because of the large number of people who wish to testify and the limitations of time. But proceed.

Mr. BROWNSTEIN. Thank you, sir.

We support the national goal of CDC and OMCH in reducing the risks, and thus we are asking for an additional $6 million to focus on the targeted risk reduction strategy. We believe that the efforts of this risk reduction strategy will be of benefit to the general public at large as we learn methods that are more effective at reducing risks and changing behaviors that are risky.

Second, we are asking through pediatric AIDS support $4 million to expand the comprehensive care network to focus on the pediatric AIDS population. Our pediatric population in hemophilia is approaching 70 percent and thus we want special initiatives directed in that area.

Our last part of that request is to provide for an AIDS education initiative in the amount of $2 million, and this is to provide support for AIDS self-help support groups. Again, this is directed at reducing the risks of transmission to sexual partners, wives, and the like. We believe and the health educators and psychologists believe that it is extremely important to complement the work of the treatment centers and the work of the National Hemophilia Foundation that the people who are directly affected by the AIDS virus themselves—that is, the people with hemophilia and their wives and other sexual partners—be directly involved in reaching the conclusions about the health risk imperatives that are involved.

The thing is that it's one thing to have a nurse or a physician do the finger-wagging in terms of you shall not do this, and it's another matter when you have people arrive at their own conclusions about the importance of reducing risks through the way they behave. So, we are urging $2 million to support that effort.

Since you did invite me to speak a little bit longer, I would like to close with about 60 seconds of a very brief history of the success that we have had that is due to the support of Congress, and that is in 1976, congressional support began in establishing this national network of treatment centers. All I can say is thank God they were in place to deal with this AIDS crisis, whereas now we have about 120 centers across the country, instead of 6,600 hospitals, where the care is regionalized and we can focus our risk reduction in AIDS education activities.

We have documented our success after the first 10 years of this program, Senator, where after the first 10 years, in-patient care has been reduced from 9.6 to 1.8 days per year in people with hemophilia. There is a 75-percent reduction in the number of days lost from work or school. The unemployment rate among adults has been reduced from 36 percent to 9.6 percent. Since 1976, over this 10-year period, the total health care costs have been reduced by 62 percent netting a $93.7 million savings in health care expenditures per year. Thus, we have a return on the investment here of over $2 billion over this 10-year period.

Senator SPECTER. Are you about finished, Mr. Brownstein?

Mr. **Brownstein**. Yes; I am.

Senator **Specter**. You are much more than double time at this point.

Mr. **Brownstein**. Well, I want to thank you very much for extending my time and the opportunity to speak with you today.

Senator **Specter**. Well, we were able to do that because you were the last one here. If we had done it earlier, it would have been twice as long.

SUBCOMMITTEE RECESS

Thank you very much. The subcommittee will stand in recess until 9:30 a.m., Friday, May 12, when we will meet in SD–192 to continue our public witness hearings on the budget request.

[Whereupon, at 12:41 p.m., Thursday, May 11, the subcommittee was recessed, to reconvene at 9:30 a.m., Friday, May 12.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR 1990

FRIDAY, MAY 12, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Burdick, and Hatfield.

NONDEPARTMENTAL WITNESSES

Senator HARKIN. Good morning.

The subcommittee will come to order.

This morning we continue with the sixth and final day of public witness testimony focusing on the programs funded by this subcommittee.

After this session, the subcommittee will have heard testimony from about 150 witnesses. As I have said before, it is a matter of regret that we have had to limit the number of witnesses that we are able to hear this year.

You have all been very understanding about our time constraints, and I again want to assure you that any witnesses who have their testimony to the subcommittee staff by May 15 will have that testimony put into the hearing record.

Again, we are going to have to use the red light, green light system. Each witness will be asked to limit their remarks to 3 minutes, so that we can afford the opportunity for each witness to have a full, or at least a fair and equal, opportunity to be heard this morning.

We have—how many do we have this morning—28 witnesses this morning, so we are going to have to proceed as expeditiously as possible.

I welcome to the subcommittee our distinguished colleague and my good friend, Senator Hatfield, from Oregon.

Senator HATFIELD. No; thank you, Mr. Chairman.

STATEMENT OF DOUGLAS BENNET, NATIONAL PUBLIC RADIO

Senator HARKIN. Our first witness today is Mr. Douglas Bennet, with the National Public Radio.

Mr. Bennet, good to see you again.

Mr. BENNET. Very nice to see you, Mr. Chairman.

Senator **Harkin**. Welcome to the subcommittee. And again, as I have said, all of your testimonies will be put in the record in full. If you would just give us a good summary, Doug, I sure would appreciate it.

Mr. **Bennet**. Thank you very much, Mr. Chairman.

I appreciate the opportunity to testify.

National Public Radio represents 366 public radio stations all over the country. I know you are both aware of them from your home States.

We live on a combination of support from listeners, from institutions, from State governments, from other sources, corporations, foundations, and, finally, a very important contribution from the Federal Government, which amounts to about 16 to 20 percent of the total revenue of the stations.

With this combination of funds, we feel that we are providing a unique information and cultural service that otherwise would not exist in the country. We are very proud of what we are doing, and we are very proud of the growth we have seen.

Our request for fiscal year 1992 is full funding of the authorization for public broadcasting, which would be $265 million, and in addition, to complete the funding for the satellite replacement.

We have a satellite interconnection system that ties all the public broadcasting stations, both radio and television, in the country together, and we are in the process of replacing that satellite system.

The request for fiscal year 1992 for satellite replacement is $143.2 million.

Mr. Chairman, confronted with the number of witnesses you will see this morning, and the number of demands on you, I think that the case I would make for public broadcasting is that we are providing a unique service, a service for which demand is growing.

In the Washington Post this morning, there is a piece on the editorial page reporting a decline in network television viewing and a decline in newspaper reading. We are not having that experience.

Our audience in pubic radio has doubled in the last decade, and we are seeing an acceleration in growth and listening, particularly to our news services.

PREPARED STATEMENT

All I can report to you about this country, which I travel around maybe almost as much as you do, is that there is a strong requirement in this population, particularly as we go into the nineties, for in-depth information and for cultural service that responds to the requirements of an increasingly multicultural society.

That is what we are trying to do. That is the case for public broadcasting, and I very much appreciate the opportunity to testify.

[The statement follows:]

STATEMENT OF DOUGLAS J. BENNET

Mr. Chairman and members of the Subcommittee, I am pleased to testify in support of appropriations for the Corporation for Public Broadcasting (CPB). National Public Radio (NPR) represents 366 public radio stations that provide news, information and performance/cultural programming to over 10 million listeners across the country.

Public radio is made possible by the special partnership of federal, state and local governments, universities, foundations, corporations and individual listeners working together to support quality programming which is otherwise unavailable in this country. In FY 1987, listeners contributed over $52 million to their local stations, comprising almost 20 percent of public radio's support. Foundations and private corporations contributed more than $36 million, almost 16 percent of total public radio income. Federal dollars are important "seed money" that leverage additional money from other sources at a ratio of six dollars for every one from CPB. In FY 1987, CPB's share of public radio's support was $52.4 million, only about 20 percent of the total.

CPB is authorized at $265 million for FY 1992, and I urge the Subcommittee to appropriate the full amount. In addition, $200 million has been authorized over three years for replacement of the public broadcasting satellite interconnection systems. For FY 1991, $56.8 million has already been appropriated; NPR requests that the remaining $143.2 million be appropriated in FY 1992. The cost to public radio for the second generation satellite system is estimated to be $54.7 million.

National Public Radio is best known for its award-winning newsmagazine programs. ALL THINGS CONSIDERED, MORNING EDITION and WEEKEND EDITION are widely acknowledged as the places to turn to for a comprehensive, in-depth, and provocative look at the day's news. ATC won the Washington Journalism Review's award for best network radio show two years in a row. Features such as "Vietnam Radio" (for which reporter Ira Glass won a Livingston Award), "Crystal Night: Prelude to the Holocaust" and "Acting White," in which Phyllis Crockett looked at black high school students' attitudes about academic achievement (and won an award from the National Education Association), are typical of the programs' eclectic fare. Reporter Nina Totenberg and NPR won the Alfred I. duPont-Columbia University Silver Baton Award for coverage of nominations to the Supreme Court in 1988.

A commitment to addressing present and future needs of a diverse society

Public radio has grown tremendously in the past decade; its audience has doubled since 1980. Support from listeners and other private sources also continues to grow. National Public Radio is now leading a planning effort to determine how public radio can best address the issues of the next decade. Toward this end, NPR in March convened a varied group of accomplished individuals to develop a vision for public radio in the 1990's. NPR's goal is to devise new programming which will be responsive to the concerns of an audience which is increasingly diverse, and defined less by geographical boundaries than by common interests and problems.

NPR is strongly committed to reflecting and serving today's critical issues. One very recent example was "AIDS and Black America: Breaking the Silence," which reported on the "second wave" of AIDS that is now spreading in the black community. Daily segments of the week-long series could be heard during ALL THINGS CONSIDERED, MORNING EDITION and WEEKEND EDITION.

In January, National Public Radio celebrated Martin Luther King Day with a two-hour program that linked three leading music schools across the country in live concerts presenting music associated with Dr. King. The program, hosted by acclaimed conductor James DePreist, was transmitted via satellite to more than 20 countries in Europe and the Soviet Union.

MORNING EDITION aired a week-long series of reports on the crisis in child health care in America. Reporters Patricia Neighmond and Michelle Trudeau examined why children are the new victims of poverty; the effects of inadequate prenatal care; nutritional assistance programs; children without health insurance; and the 25-year-old Headstart program.

National Public Radio has helped to create a renewed interest in radio drama through its national distribution of California station KCRW-FM's production of "Babbitt." In April, NPR began distribution of the five-part "Beckett Festival of Radio Plays," produced by Voices International. These premiere performances of Beckett's radio plays feature all-star casts including Amanda Plummer and Billie Whitelaw; each program also includes a short documentary on the play and its place in the context of the author's work.

A means of examining our culture, our character

The landscape of the arts in America is undergoing vigorous change, requiring a constant reexamination of public radio's cultural role. America's growing interdependence with other countries requires a broader understanding of other peoples. As the language of culture, the arts are struggling to come to grips with the country we are becoming. National Public Radio expects to increasingly act as a forum for an emerging American cultural sensibility.

As part of this reexamination, NPR is reformulating its daily arts magazine, PERFORMANCE TODAY. In the new format, a one-hour, five day-a-week program of serious reporting and analysis of American cultural diversity will be complemented by two hours of current classical broadcasts from around the country, reflecting the majority music interest of our listeners. In the spirit of diversity, NPR's performance offerings will also include "Mountain Stage" from West Virginia, "Marian McPartland's Piano Jazz" from South Carolina, "Afropop Worldwide" recorded internationally, and "Car Talk" from Boston.

Public radio is a unique national/local partnership

The contributions of local public radio stations are integral to the success of NPR's daily and weekly programs, helping to bring the rich diversity of the American experience to listeners across the country. This national/local partnership also enables NPR to draw from the talents of independent producers, who in FY 1988 contributed approximately 20 percent of the program hours in ALL THINGS CONSIDERED, MORNING EDITION, WEEKEND EDITION, and specialized audience programming. In addition, independent producers contributed 38 percent of the drama program hours -- NPR PLAYHOUSE, for example -- and 26 percent of classical music program hours distributed by NPR are independently produced.

Public radio is more than national programming from NPR and other national producers and distributors. Funding from CPB, listeners, and the many other sources that support public radio allows member stations to produce local programming uniquely responsive to the special needs of their communities.

In Iowa, KTPR-FM, Fort Dodge, sponsored its second annual community Christmas celebration. In cooperation with merchants, the station sponsors free concerts, a sing-along, and children's art activities to help rejuvenate Fort Dodge's economically depressed downtown area. KTPR also recently coordinated an amateur photo contest in which winning photos of north central Iowa were exhibited in various rural libraries.

The University of Iowa's station, KSUI-AM, Iowa City, has carried gavel-to-gavel coverage of the Iowa legislature for many years; it is a service valued highly by its listeners.

Station WXPN-FM in Philadelphia, Pennsylvania is working to increase interracial understanding in the community through its "World of Difference" programming. These daily features resulted in public hearings on the drug problem in Philadelphia. The broadcast of these hearings earned the station a nomination for CPB's award for best public service programming.

In California, KALW-FM, San Francisco, serves its substantial Chinese-speaking community through Cantonese simulcasts of a local TV station's evening newscast. Community outreach organizations have attested to the widespread use of the program among Chinese-speaking San Franciscans, for whom it is the only source of TV news in their native language.

Station KVPR-FM in Fresno has had recent success with a program which gives students from a local school for the gifted the opportunity to produce news stories for the station. A group of fifth-graders has completed a story on noise pollution in the classroom and its effect on children; it will air in May. The station also worked with high school students who produced three-minute commentaries; a different student's commentary was featured every day for a week.

A need to reach more Americans and to serve them better

Public radio has made a commitment to expand to reach unserved and underserved audiences, including the fourteen percent of Americans who still are not able to hear any public radio signal. This expansion can be accomplished in part by increasing the number of CPB-qualified stations without diminishing the effectiveness of stations already on the air.

If the full $265 million authorized for FY 1992 is appropriated, it will permit CPB to begin to increase the federal share of the average station's budget which will reinforce the ability of stations to produce locally. In 1988, 70 percent of the money distributed by CPB to qualified radio stations was used for programming -- 51 percent of those funds are used for national programming and 49 percent for local programming. NPR's programming increasingly relies on stations' input -- many of the most successful nationally distributed shows, such as "Fresh Air" and "Car Talk," began as local productions. In addition, programs such as PERFORMANCE TODAY and the new expanded newscasts are built around substantial contributions from local stations. An increase in the federal share of stations' budgets will have a significant impact on both the national and local programming available to public radio listeners.

Expansion of the satellite interconnection system will allow many stations currently outside the CPB system to share in public radio's extensive and growing repertory of national programming. It also will create additional outlets to expand the market for program producers, increasing the available audience, creating additional revenue in acquisition fees, and presenting a more attractive carriage report to underwriters and foundations.

New satellite technology is the key to sharing, creating national community

In FY 1992, the first operational year of the second generation satellite interconnection system, public radio will face new technical and financial challenges. The commitment by Congress of $200 million for the satellite system assures the future availability of diverse public radio and TV programming across the country. The $56.8 million appropriated for 1991 allows public broadcasting to start down the road to the future, but much of the remaining $143.2 million needed to complete the planned systems will be required even before the FY 1992 appropriation is available. It is essential, therefore, that those funds be available in FY 1992.

Public radio must switch to a new satellite, with no interruption in program distribution, by the middle of calendar year 1991. As space segment negotiations have progressed between NPR and vendors, it has become apparent that purchase of capacity for the future will be more economical than leasing. In fact, the most favorable prices available will require considerable up-front payment, and any capacity will have to be entirely paid for when service is initiated. Financing costs will be minimized if all remaining authorized funds are appropriated for FY 1992, allowing public radio to stretch each federal dollar to its maximum.

The current satellite has enabled public radio stations to enjoy a growing variety of program choices. During 1988, 237 different producers distributed 21,227 hours of programming through the channels of the public radio satellite system. Studies indicate continued growth in the number and types of users of the public radio satellite system, which will require additional distribution capacity. The prospect of future digital audio services also mandates that the satellite have the capacity to incorporate new services and technologies. Therefore, public radio intends to acquire two transponders for the second generation system. Factors in the satellite transponder marketplace which indicate a shortage of capacity in 1993 or 1994 necessitate the early purchase of transponders to avoid paying much higher prices for a scarce commodity. Early purchase will also ensure that a second transponder will be available on the same satellite as other public radio services, an additional cost-saving measure/factor.

Mr. Chairman, National Public Radio requests that the full $265 million authorized for CPB, plus $143.2 million for satellite replacement be appropriated for FY 1992. In a time of budget austerity, money spent on our public broadcasting system is a wise investment in the future of this country. The programming available on public radio not only enriches us culturally, but also goes a long way toward helping us to identify and solve our most pressing problems. With your help, we can do even more in the future.

Senator HARKIN. Mr. Bennet, thank you very much for your testimony.

Let me ask you about that satellite. You say you have to switch to a new satellite by when? 1991?

Mr. BENNET. By 1991.

Senator HARKIN. And the one you have up has been up for how long?

Mr. BENNET. Since 1979. I think I am accurate—let me give you that. But in any case, the satellite goes out of service because the fuel to adjust its position is exhausted. That is predicted to happen in 1991, so this will be our second generation satellite.

Senator **Harkin**. I see.

So a whole new satellite has to be put in orbit.

Mr. **Bennet**. In addition to that, some ground service, port facilities for communicating with it.

Senator **Harkin**. I see.

Mr. **Bennet**. I should explain that we are not launching a satellite. We will be buying transponders on satellites launched commercially.

Senator **Harkin**. I see.

And if—what would happen if, for example, we do not give the full funding of the $143.2 million, but something considerably less? Something? What happens? Will you be able to buy that, or not?

Mr. **Bennet**. We will have to have committed to buy the satellite by the end of this year, in all probability.

The result of less than full funding would be to increase the financing charges substantially, and the effect of that would be to increase the cost, the operating cost to stations.

The satellite system is like electricity. I mean, we simply cannot do what we do without it.

Senator **Harkin**. You are requesting $265 million for public broadcasting, and $143.2 million—that would be the end of the funding for the satellite interconnection?

Mr. **Bennet**. That would be the final tranche, yes.

Senator **Harkin**. Thank you very much.

Mr. **Bennet**. Thank you, Mr. Chairman.

STATEMENT OF ARLENE PESSAR, EXECUTIVE DIRECTOR, DEBRA OF AMERICA

ACCOMPANIED BY:

ERIC LOPEZ
MARY DAVIS
BOBBY DAVIS

Senator **Harkin**. Our next witness is Arlene Pessar, executive director of DEBRA of America, that is the Epidermolysis Bullosa Research Association of America.

She is accompanied by her son, Eric Lopez, and, of course, Mary Davis, who is from my home State of Iowa, and her son, Bobby, of Council Bluffs, whom I just met up in my office.

We welcome you here to the subcommittee.

Senator **Hatfield**. Mr. Chairman, may I have the privilege of presenting these people representing epidermolysis bullosa and the problems relating to that particular medical problem?

Mr. Chairman, a number of years ago, we on this committee became aware of this rather, I suppose you could call it an orphan disease, and launched the first medical research program. Much of it is because of some very remarkable people. Arlene Pessar being certainly one such person who helped create parents and citizen awareness, and brought this to not only this committee's attention, but to the whole country.

I just want to take this moment to commend her, and really, she is sort of the front for the real power behind this, in that Eric has been the real witness over the years, and we had another gentleman by the name of Larson, who is not with us now, but who also, along with Eric, helped create this awareness and appealed to this committee for some moneys for this research.

I am not—my ability to describe is very limited, but theirs is very gifted, and I am very happy to join the chairman, Senator Harkin, who I know will be as enthusiastic as those of us who have been associated with this particular problem have been in the past, because Senator Harkin is a man of great compassion and great understanding, great sensitivity. We are awfully lucky to have him as our chairman.

So I am very happy to present these folks to you.

Senator **Harkin**. Thank you very much for those kind words.

I am happy to meet Bob and his mother, too.

I just met them up in my office. Sorry I was running so fast—I had to get to another subcommittee before I even got here.

Senator **Hatfield**. My remarks did not take time from you. They are over and above your time.

Senator **Harkin**. That is right. You can start that again.

Welcome to the subcommittee and please proceed. We are delighted to have you here.

Ms. **Pessar**. Thank you, Chairman Harkin and Senator Hatfield.

We had a lot of help over the past years, and I have to thank Senator Weicker, who is no longer in the Senate. He has been a big supporter of ours, along with Senator Hatfield, and other members of the committee over the years.

Let me begin by saying thank you, and telling you how much we appreciate your request to accommodate our request to testify this morning.

Our participation in this important legislative process is very important, and we are grateful you have given us this opportunity to share our views.

Since Eric is making his own statement this morning, I am going to limit my remarks. You have already met Bobby and Mary from Council Bluffs, IA. Mary has been one of the founding mothers, along with Estelle Larson and many others.

Before Eric goes, there is just one urgent recommendation I would like to make to the committee. Last year, the subcommittee directed the National Institute of Arthritis and Musculoskeletal and Skin Diseases to begin planning for the establishment of specialized research centers in epidermolysis bullosa.

Even though the Institute did receive additional funds for basic research grants, the budget did not allow for the establishment of any new dermatology centers.

In addition to providing funds for individual research grants and training fellowships, the NIAMS budget must be increased in order to expand the dermatology centers program. It is for this reason that we respectfully request that the committee provide an additional $1 million to the NIAMS budget in fiscal year 1990, to support the establishment of two specialized epidermolysis bullosa centers.

PREPARED STATEMENT

Mr. Chairman, we know these are very trying economic times, and difficult decisions must be made. But now is the time to accelerate the work that you have started. Bobby and Eric's future, and the future well-being of thousands of other children, some not yet born, depend on your leadership and continued support.

As long as children continue to be born with epidermolysis bullosa, we must do everything possible to keep them living fuller and more productive lives.

Thank you.

Senator **HARKIN**. Thank you.

[The statement follows:]

STATEMENT OF ARLENE PESSAR

I am pleased and honored to be here today to update you on the progress of Epidermolysis Bullosa (EB), and grateful to have the opportunity to participate in this important process.

I am Arlene Pessar, founder and executive director of the Dystrophic Epidermolysis Bullosa Research Association of America (D.E.B.R.A.). I am also a member of the Advisory Council of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), and serve on the Board of Directors of the National Organization for Rare Disorders (NORD), and several other voluntary health organizations and coalitions. Most importantly, I am the parent of an 18-year old son with Epidermolysis Bullosa, an incurable and debilitating skin disease.

Epidermolysis Bullosa (EB) is an inherited group of disorders that affects more than 50,000 Americans, mostly children. The morbidity and mortality are high and many patients either die in infancy, or within the first two decades of life. The clinical symptoms range from severe, fatal blistering in the newborn to milder blistering when skin is stressed by pressure, such as walking, mowing the lawn, or typing a letter.

In the severe dystrophic forms, generalized blistering results in loss of body fluids, electrolytes, blood, and proteins through eroded surfaces; dehydration, anemia and growth retardation are frequent complications. Blisters in the mouth and esophagus may interfere with swallowing, and anemia and stunted growth are probably related to nutritional losses. Scar tissue of the nasal passages and larynx make breathing difficult, and blistering of the cornea causes severe pain, and in a few cases, blindness. Continuous blistering leads to scarring that causes disfigurement and deformity of fingers and toes and arms and legs. Eventually patients succumb to overwhelming skin infections or develop aggressive skin cancers in scarred areas.

The medical and surgical costs per patient are enormous. These expenses are usually not covered by standard health insurance policies and many families are forced to publicize their plight by asking their local church groups and civic organizations to help them meet the cost of mounting medical bills.

D.E.B.R.A. of America, Inc., founded in 1980, is the only national voluntary health organization working to cure Epidermolysis Bullosa (EB); to promote research, education, and advocacy, and to provide services and support for people with EB and their families.

This is the eighth year we have come before this committee and you, Mr. Chairman, and the other members have listened to us with compassion and understanding. In 1982, this committee first recognized that "epidermolysis bullosa is a life-threatening genetic disease" and directed that funds be used to expand the research programs on EB. Since then, a great deal of progress has been made towards increasing the understanding about this terrible disease.

For example, researchers funded through the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) are using new scientific technologies to understand the basic defects in EB, specifically of the basement membrane zone. Most recently researchers have identified a specific structure (called Type VII collagen) missing in the layers of skin of patients with recessive dystrophic EB, the most severe form.

Another very exciting area is the identification and enrollment of large numbers of patients into the National EB Registry. In addition to collecting important data, patients are being clinically evaluated and referred to medical and surgical specialists, when necessary. We expect the information from the registry will provide new insights and stimulate additional scientific interest about this complex disease. The next step to further capitalize on this success is the establishment of multidisciplinary EB centers.

Last year the committee recognized that the NIAMS was severely underfunded and recommended an increase in the Institute's budget so that a higher number of approved grants could be funded. We are extremely grateful to you for this generous support, but we are disheartened that this appropriation did not allow for the establishment of dermatology centers. In addition to providing funds for basic research grants and training fellowships, the NIAMS budget must be increased in order to expand the dermatology centers program. It is for this reason that D.E.B.R.A. supports the recommendations of the Coalition of Voluntary and Professional Associations Concerned with the Programs of the National Institute of Arthritis and Musculoskeletal and Skin Diseases and urge you to approve a funding level of, at a minimum, $192 million for FY 1990, to bring the level of support for the Institute up to par with other NIH institutes.

Mr. Chairman, before I leave here today there is one more urgent request I must make. Last year the Committee's final report directed the NIAMS to "begin planning for the establishment of a limited number of SCORS (specialized centers of research) in EB and other catastrophic skin diseases." We know these are trying economic times, but now is the time to continue the work that you have started. Therefore, I respectfully request that the committee provide an additional $1 million to the NIAMS budget to support the establishment of two specialized EB centers. Centers are the best way to accelerate research in a specific area and have proven to be highly successful in addressing the needs of other complicated genetic diseases, such as cystic fibrosis. Moreover, through the National EB Registry, there is now a large group of patients eagerly willing and waiting to participate in basic and clinical research projects. In the attached chart, I have outlined how one such center might be organized.

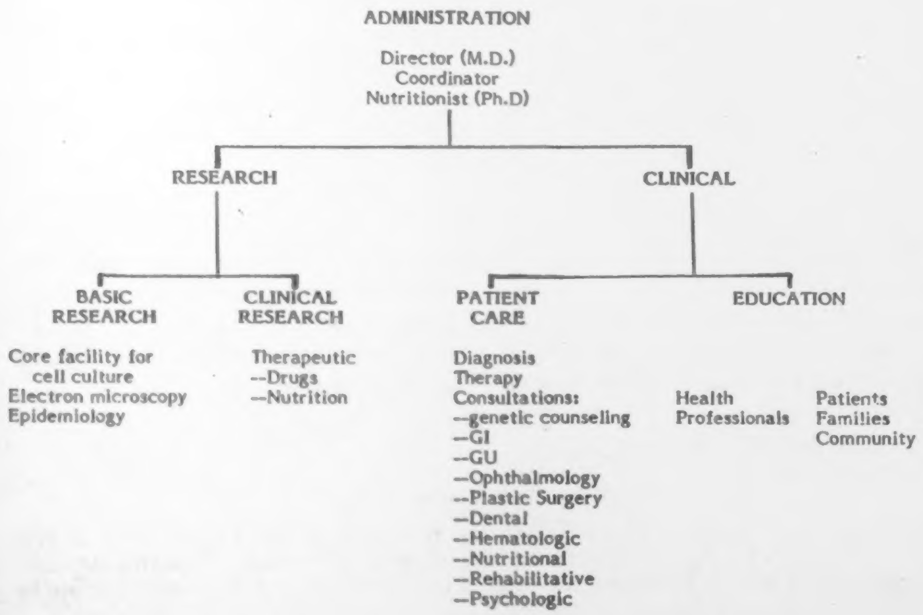
I know it is easy for me to request this type of support, and you have the tough job of making the decisions, but I also know that my son's future well-being, and the lives of thousands of other children, depends on your leadership and support. As long as children continue to be born with EB, we must do everything possible to help them live fuller and more productive lives.

Thank you for giving me this opportunity to express my concerns. Your support has made a difference. I urge you to continue to make a difference.

SUMMARY OF RECOMMENDATIONS

1. That a minimum of $192,000,000 be approved for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS); and,
2. **That $1,000,000 be added to the NIAMS budget to support the establishment of two specialized EB Centers.**

SPECIALIZED CENTER OF RESEARCH IN
EPIDERMOLYSIS BULLOSA


ADMINISTRATION
Director (M.D.)
Coordinator
Nutritionist (Ph.D)
RESEARCH
CLINICAL
BASIC RESEARCH
CLINICAL RESEARCH
PATIENT CARE
EDUCATION
Core facility for cell culture
Electron microscopy
Epidemiology
Therapeutic
--Drugs
--Nutrition
Diagnosis
Therapy
Consultations:
--genetic counseling
--GI
--GU
--Ophthalmology
--Plastic Surgery
--Dental
--Hematologic
--Nutritional
--Rehabilitative
--Psychologic
Health Professionals
Patients
Families
Community

STATEMENT OF ERIC LOPEZ

Senator HARKIN. Eric, welcome to the subcommittee.

Mr. LOPEZ. Thank you.

Mr. Chairman and Senator Hatfield, my name is Eric Lopez.

You know me because I have accompanied my mom, Arlene Pessar, many times before. However, now that I am 18, I feel it is important for me to take on this responsibility because it is for me and other people with epidermolysis bullosa that she has worked so hard for over the years.

I was born with a rare, chronic and painful skin disorder called epidermolysis bullosa. ED has managed to make my life difficult, especially in the last few years, which are normally trying for any person my age.

Last year, I graduated from high school with academic honors and was very proud of myself. Even more so, I was eagerly looking forward to starting college. My goal is to become an automotive engineer, something I have wanted since I was 6 years old.

I applied and was accepted to Polytechnic University in Brooklyn, NY. Polytechnic University is a school dedicated to engineering, and ranks high among the Nation's educational institutions.

September came, and I was ready. College was going to open up a new world for me, academically and socially. Well, to make a long story short, I withdrew from school before the first semester ended.

Since then, I have been spending much of my time at home, trying to make some decisions about my future. All of my life, I have considered myself a pioneer, overcoming obstacles, opening doors, and fighting discrimination and ignorance about epidermolysis bullosa.

Few people with severe epidermolysis bullosa have had the opportunities and experiences I have had, either because they die at an early age, or because their bodies have become so debilitated that it is physically impossible.

Mr. Chairman, Mr. Hatfield, I have been a strong role model and advocate, and I have helped to make life a little better for other patients with epidermolysis bullosa. More importantly, I am here today because I still have hope, and believe you have the power to help us win the fight against epidermolysis bullosa.

PREPARED STATEMENT

That is why I am urging you to continue to fund and expand the research on epidermolysis bullosa, research that is still desperately needed to develop new treatments and a cure, research that probably will not directly help me, but may help other lives from being devastated by this terrible disorder in the future.

Thank you.

[The statement follows:]

STATEMENT OF ERIC D. LOPEZ

Mr. Chairman, members of the committee, my name is Eric Lopez. Many of you know me because I have accompanied my mom, Arlene Pessar, before this committee many times before. However, now that I am 18, I feel it is important for me to take on this responsibility, because it is for me, and other people with EB, that she has worked so hard for over the years.

I was born with a rare, chronic, and painful skin disorder called Epidermolysis Bullosa. EB has managed to make my life difficult, especially in the last few years, which are normally trying for any person my age.

Last June, I graduated high school with academic honors, and was very proud of myself. Even more so, I was eagerly looking forward to starting college. My goal is to become an automative engineer; something I've wanted since I was six years old.

I applied and was accepted to Polytechnic University in Brooklyn, New York. Polytechnic University is a school dedicated to engineering, and ranks high among the nation's educational institutions. September came, and I was ready. College was going to open up a new world for me, academically and socially.

Well, to make a long story short, I withdrew from school before the first semester ended. Since then I've been spending much of my time at home trying to make some decisions about my future.

All of my life I have considered myself a pioneer, overcoming obstacles, opening doors and fighting discrimination and ignorance about EB. Few people with severe EB have had the opportunities and experiences I have had. Either because they die at an early age, or because their bodies have become so debilitated it is physically impossible.

I am here today because I have been a strong role model and advocate and have helped to make life a little better for other patients with EB. More importantly, I am here today because I still have hope and believe you have the power to help us win the fight against EB. That's why I am urging you to continue to fund and expand the research on EB. Research that is still desperately needed to develop new treatments and cure. Research that probably will not directly help me, but may help other lives from being devastated by this terrible disorder in the future.

Thank you.

Senator HARKIN. Thank you very much.

Bobby, do you have anything else you want to add to this? I know you do not have a prepared statement, but we welcome you here.

Mr. DAVIS. I am glad we are here today.

Senator HARKIN. OK, well, that is good.

Well, thank you all very much, and Eric, that was a very good statement.

Mr. LOPEZ. Thank you.

Senator HARKIN. I have just got to tell you how proud I am of you, and what you have been doing.

When they talk about profiles in courage, you have got to rank right up there at the top of them.

Mr. LOPEZ. Maybe I will be on TV or something. [Laughter.]

Senator HARKIN. Probably.

Well, you are one of my heroes, that is what I can tell you right now.

I know that it has been tough. I know that it has been a long struggle for you. I can assure you that we are going to do the best we can.

Mr. LOPEZ. Thanks a lot.

Senator HATFIELD. Mr. Chairman, I have nothing further to add. It would be anticlimactic, except to say that I sort of have to take another moment to pay tribute to Cal Larson.

Cal, I think, was one of our first witnesses up here—is that not true, Arlene?

Cal Larson comes from Maryland, and not only did he come here to testify, as a first-time witness, urging some research money for this particular disease, but Cal Larson could be seen charging up and down the hallways here in his wheelchair. He reached a point of immobility, and he would go in and out of the offices. He called on every subcommittee person on this committee, and he could, and did, in a very eloquent fashion, give the facts, the figures, the background, the data.

And Eric, as well—boy, they made a combination and a pair. Eric, you are carrying on for Cal Larson and your great tradition, and it is a very great contribution you are making to this committee and to the cause of humanity.

Thank you both.

Bob.

Senator **Harkin**. We will do our best, and come back next year and we will do some more, OK? We will get more in there for next year, and we will win this battle.

Again, I will just say that we have had so many, especially young people, who have testified at these hearings for the last several weeks, who have had one form of disability or another, and what has come through very clearly is that whatever disability it might be, it only limits that human being in that particular disability, but it does not limit them in any other fashion, whether it is deafness, blindness, muscular dystrophy, or this thing I cannot even pronounce—it is called what, dystrophic—you are going to have to help me with this.

Ms. **Pessar**. It takes a lot of years to get it.

Senator **Harkin**. Have to get my mouth working right on this one. But it is obvious you are very intelligent, you are very bright, an honor roll student, a bright future. I tell you, once again, it just shows that we ought not to be looking at people with disabilities and seeing what they cannot do. We ought to look at them and see what they can do—and you can do a lot.

Thank you very much.

Mr. **Lopez**. Thank you.

Ms. **Pessar**. Thank you.

STATEMENT OF GERALDINE DIETZ FOX, EXECUTIVE DIRECTOR

ACCOMPANIED BY:
RACHEL DUBIN
CINDY CAMPBELL

Senator **Harkin**. Next, Mrs. Geraldine Dietz Fox, a very dear friend of mine, executive director of the Friends of the National Institute on Deafness and other Communications Disorders.

Geraldine, welcome to the subcommittee.

You are accompanied by someone I have met before, I think?

Ms. **Fox**. Yes; I believe you have met Rachel Dubin before. That is your friend.

Senator **Harkin**. I have. Yes; Rachel, you and I have met before, about a year or so ago.

Yes; I remember you well.

Ms. **Fox**. This is the young lady who sat in your chair last year, in your office, and decided that maybe she did not want to be an actress, but that she would rather be a Senator.

Senator **Harkin**. I know. And I told her that her time would come—let me serve out mine first.

Very, very bright. I remember her well.

Ms. Fox. Well, thank you. It is a pleasure to be here. Good morning, Senator Harkin, Senator Hatfield, and members of the legislative staff.

I am here today representing the Friends of the National Institute on Deafness and other Communication Disorders, and we are a group of citizens and organizations who are working for the expanded research, training, and development of NIDCD.

We want to convey to you and members of your committee our gratitude for your tireless efforts and your dedication to basic medical research.

We are prepared to meet the challenge, and ask you to consider our appropriations justification request of $140 million. I would like to thank you for the opportunity to make a brave new world for persons all over by giving them back their dignity and their joy in living.

PREPARED STATEMENT

I do not want to take any more time, because I have such spectacular people with me today, and I would like you to speak to Rachel Dubin now.

Senator Harkin. Well, I want to hear from Rachel.

[The statement follows:]

STATEMENT OF GERALDINE DIETZ FOX

Good afternoon Chairman Harkin and Members of the Subcommittee. I am here today representing the Friends of the National Institute on Deafness and Other Communication Disorders; a coalition of organizations and private citizens dedicated to work for expanded research, training and development of NIDCD. Although we have only been inviting membership for eight weeks, we already have 2½ million supporters. We have attached a partial Citizens Committee List to this testimony.

Chairman Harkin, we all want to convey to you, and the Members of your Subcommittee, our gratitude for your tireless efforts, concern, and support of the passage late last year of legislation creating and funding the new Institute. We also want to recognize the magnanimous contributions of your fellow congressional leaders, Senators Edward Kennedy, Barbara Mikulski, and Orrin Hatch; and most particularly, Senators Arlen Specter, Daniel Inouye, Thad Cochran, Quentin Burdick, and Brock Adams who lent substantial support by Co-Sponsoring S. 1727, the Bill which established the NIDCD.

It is because of your dedication to basic medical research and insisting we find solutions to this monumental problem which afflicts 33 million Americans, that we will now focus all our energies on alleviating and curing hearing and other communication disorders.

With the funds provided for NIDCD for fiscal year 1989, we are only able to continue to support the programs that already existed under the Neurology Institute.

Now, in order to comply with the supplemental work mandated by Congress in its enacting legislation, the NIDCD requires substantial additional resources. We need to bring this new Institute up to a point of parody with other NIH Institutes addressing biomedical questions.

The response of the medical and professional communities to the establishment of this Institute has been overwhelming, and there is enormous enthusiasm and concern to address your objectives.

We are prepared to meet the challenge and ask you to consider our appropriation request of $140,000,000. I am enclosing the Justification for the fiscal year 1990 NIDCD Budget which led us to this specific request level, and would be happy to answer any questions you have regarding this proposal.

We would like to thank Dr. Jay Moscowitz for his superb job as Acting Director in guiding us with clarity, foresight, and fairness. We feel privileged to have his counsel.

Again, we thank you, more than we can ever express, for the opportunity to make a brave new world for persons all over . . . by giving them back their dignity and joy in living in this modern age of communication. We will always be grateful for your sensitivity to the human and medical needs of this segment of our population. Your faith in us is treasured and we promise, we won't let you down.

STATEMENT OF RACHEL DUBIN

Ms. DUBIN. Thank you for your remarks.

Hello again, Senator Harkin, Senator Hatfield, and members of the staff and committee. I hope you remember me.

My name is Rachel Dubin. I testified before you last year hoping that you would establish a new institute to help kids like me, and you did. I came back to thank you for all the speech- and hearing-impaired kids, and to testify this year on behalf of the Deafness Research Institute funding.

I am now 12 years old and in the seventh grade at Park School. I am profoundly hearing impaired. I am increasing my ability to listen, by taking lessons in auditory training. I am now listening to classical music tapes, listening for the ring of the telephone, and I can even talk on the phone alone, by asking questions and listening for the words "okay" or "no."

As for school this year, I'm very involved in activities. I was a stage manager for the middle school's production of Gilbert and Sullivan's operetta "Iolanthe" and joined the girl's winter soccer team because I wanted to meet new people and have them get to know me.

That's the good news. However, there is bad news too. In the small groups of science and drama, kids exclude me from decisions and discussions. In drama, they say I can't be part of the drama skit because I don't know anything, and if I do get a part, it will have to be a nonspeaking part. That frustrates me, because I love to talk.

In the science labs, I'm used as a "go-fer" to do things like fill the flasks; but they tell me not to touch the experiment. Senators, I love my school, my teachers, and my classes. Most of all, I love to learn. I just want to be included in it all.

At school and parties, kids tend to ignore me, and don't include me in their conversations. At the lunch table, they often say to me, "Stop reading our lips, Rachel!" and this really frustrates me because that's the only way I hear.

Senators, please fund deafness research as generously as you can, to help me and other hearing-impaired kids to be a part of the world in which we are so anxious to be fully participating individuals.

Thank you, Chairman Harkins and members of the subcommittee, for allowing me to speak today.

[The statement follows:]

STATEMENT OF RACHEL DUBIN

Hello again, Chairman Harkin and members of the subcommittee. I hope you remember me. My name is Rachel Dubin. I testified before you last year, hoping you would establish a new Institute to help kids like me—and you did. I came back to thank you for all the speech and hearing-impaired kids, and to testify this year on behalf of the Deafness Institute funding.

I am now 12 years old, and in the 7th grade at Park School. Although I am profoundly hearing impaired, I am increasing my ability to listen, by taking lessons in auditory training. I am now listening to classical music tapes, listening for the ring of the telephone, and I can even talk on the phone alone, by asking questions and listening for the words "okay" or "no."

As for school this year, I'm very involved in activities. I was a Stage Manager for the Middle School's play production of Gilbert and Sullivan's operetta, Iolanthe and joined the girl's winter soccer team because I wanted to meet new people and have them get to know me.

That's the good news; however, there's a lot of bad news, too. In the small groups of science and drama, kids exclude me from decisions and discussions. In drama, they say I can't be part of the drama skit because I don't know anything, and if I do get a part, it will have to be a non-speaking part. That frustrates me because I love to talk.

In the science labs, I'm used as a "go-fer" to do things like fill the flasks; but they tell me not to touch the experiment. Senators, I love my school, my teachers, and my classes. Most of all, I love to learn. I just want to be included in it all.

At school and parties, kids tend to ignore me, and don't include me in their conversations. At the lunch table, they often say to me, "Stop reading our lips, Rachel!" and this really frustrates me because that's the only way I hear!

Senators, please fund deafness research as generously as you can, to help me and other hearing impaired kids to be a part of the world in which we are so anxious to be fully participating individuals.

Thank you, Chairman Harkin and members of the subcommittee, for allowing me to speak today.

Senator **HARKIN**. Rachel, it is wonderful to have you back here again.

Ms. **DUBIN**. I'm sorry?

Senator **HARKIN**. OK. I am very happy to see you back here again.

Ms. **DUBIN**. Thank you.

Senator **HARKIN**. I also want you to know that the Institute would not have happened without the person sitting to your left, Mrs. Dietz, who worked so hard pounding in all of our doors and getting us to do the right thing.

Ms. **DUBIN**. Thank you.

Senator **HARKIN**. She was just wonderful.

Did any of the other two of you have anything that you wanted to add?

STATEMENT OF CINDY CAMPBELL

Ms. **FOX**. I would like you to meet Ms. Cindy Campbell, on the end, and she has a very interesting story. She has a cochlear implant.

One second.

Ms. **CAMPBELL**. Good morning.

Chairman Harkin, Senator Hatfield, and members of the subcommittee. My name is Cindy Campbell. I appreciate your having me here today to speak to you.

I would like to speak to you about the rapid and terrifying decline of my hearing, what had happened, and my climb back into life after receiving a cochlear implant.

I did not realize that I had a hearing impairment until I was 10 years of age. When I was 10 years of age, the hearing in my right ear had declined, and when I was 18, the hearing in my left ear worsened very quickly.

At that time, my dreams of becoming a nurse were shattered, because I could no longer hear through a stethoscope. By the age of 28, I was totally deaf.

My saddest loss was that I could no longer interpret for my husband, who is hearing impaired. I met my husband at Gallaudet University, from where I graduated college.

I heard about the cochlear implant program and I volunteered to receive an experimental implant. After using the implant for about 3 months every day, I was able to understand people in certain situations without lipreading. After 6 months, I was brave enough to talk to friends on the telephone.

I now understand 80 to 85 percent without lipreading in conversations.

As a vocational rehabilitation counselor, I interpret for my clients and have been successful in finding jobs for the greatest number of deaf adults in my State, who might normally remain on financial assistance programs.

Becoming deaf was a devastating and shattering experience for myself and my husband. To have gained most of my hearing back through the cochlear implant has been a wondrous blessing, and has allowed both of us to become independent again.

Mr. Chairman, I implore you to allocate funds for the Deafness and Communications Disorders Institute. Making cochlear implants available for other individuals with hearing impairments will improve the quality of their lives and allow them to participate in a hearing society.

Thank you.

Senator **HARKIN**. Thank you, Ms. Campbell.

Do you have a single or multiple channel?

Ms. **CAMPBELL**. Multichannel—22 channel.

Senator **HARKIN**. 22 channel. Where did you have it done?

Ms. **CAMPBELL**. I had it done at NYU Medical Center.

Senator **HARKIN**. So how many years has it been?

Ms. **CAMPBELL**. I had it done in 1984. I was part of the experimental program.

Senator **HARKIN**. I understand the multichannel is really the way to go, rather than the single channel.

Ms. **CAMPBELL**. I think so.

I have met some people who have had the single channels, but I have also heard that some people with single channels have done very well as well.

Senator **HARKIN**. We do not really know all the answers yet, on that.

Ms. **FOX**. Senator Harkin, I just want you to meet a friend who came from New York City, and he wants to say two words to you. He is Robert White, an opera singer, and he has sung for many, many Presidents in the White House.

Senator **HARKIN**. Well, we are delighted to have you here, Robert.

Mr. **WHITE**. Thank you, Senator Hatfield, Senator Harkin.

My whole work has been with voice, vocal disorders, and communication, and I wonder, in the brief 40 seconds or so that I might have, my appropriate way of communicating which is about feelings that everyone here is dealing with and love for their fellow man—I would like to know if it would be appropriate to do one chorus of "Smiling Through?"

Senator **Harkin**. Delighted [laughter] it might be the best thing that has happened to this subcommittee for a long time.

Go right ahead.

[Mr. White sings "Smiling Through".]

[Applause.]

Senator **Harkin**. I knew there were a lot of reasons I wanted to be here today, but I did not know about this. Wonderful.

Mr. **White**. Well, thank you.

Senator **Harkin**. We are most appreciative.

It is my joy. I have the songs here for you both, if I may leave them to be presented for your pleasure later, OK? Thank you.

Senator **Harkin**. It is truly wonderful to be here and to brighten up the whole day for us, just as Rachel has brightened up our day for us, and the witnesses before.

One of the fun things about being chairman, or even being on this subcommittee, is just to see the real joy of life come through.

Mr. **White**. That is what it is all about.

Senator **Harkin**. Just wonderful.

Mark.

Senator **Hatfield**. I have a very simple message for Rachel.

[Senator Hatfield signs to Ms. Dubin.]

Ms. **Dubin**. Thank you.

Senator **Harkin**. She is great.

Senator **Hatfield**. Thank you, Mr. Chairman.

Senator **Harkin**. Geraldine, thank you again for all of your tireless effort. We got it through, and do not worry, we are going to take care of it.

All right, thank you all. Thanks, Rachel.

STATEMENT OF KNUT RINGEN, DIRECTOR, LABORERS' INTERNATIONAL UNION OF NORTH AMERICA

Senator **Harkin**. Yes; now Dr. Knut Ringen, Laborers' National Union.

Don, did you want to join him at the table?

Mr. **Ringen**. Thank you very much, Mr. Chairman and Senator Hatfield. That is a hard thing to follow.

I represent today the 500,000 members of the Laborers' International Union of North America and the 2 million people who receive medical care insurance through the 154 health plans operated by our local affiliates.

We have large numbers of members in both Iowa and Oregon, as you know, and we appreciate the opportunity to be here today.

Laborers' Union and their signatory employers have started a very large health program in recent years. The reason for that is that the Federal Government simply is not doing what it should be doing in this area, but even with the large program that we have started, and the cooperation that has been developed, the problems that workers face in terms of health are too large for labor and management to handle alone, and the Government has to be active here.

My testimony today relates to the need to reinvigorate the public health service's efforts with regard to workers' health.

Workers at industry, construction, farming, and the services, the blue-collar workers in our country, the 40 million or so workers who fall into those categories, have death rates that are much higher than average in the population.

A laborer has death rates that are two and one-half times higher than the average, or five times higher than, for instance, a physician or a teacher. Now, labor in this country can expect to live 10 years shorter than these other occupations, and few people are aware of this gross inequality that exists—something that just is not fair.

Laborers and other workers face very high risks of death from sources or risks on the job and off the job, and yet they are compartmentalized so that one agency of the Government deals with occupational safety and health, and everybody else deals with that which is off the job, and there is no combined effort to deal with the total health picture that laborers face.

The cost of premature disability and death due to occupational factors in the United States is staggering—probably $1 trillion at this time. And workers and their families have to pay for almost all of that themselves. When you see a disabled worker, you are going to see somebody who has family problems, who has a wrecked home, who has ruined finances, and all of the things that go with the serious economic consequences of disability at this time.

The public health service programs to protect workers' health have declined precipitously in the 1980's. Under the President's current budget, the National Institutes for Occupational Safety and Health would receive less than one-third of its budget in 1981, less than one-third.

Senator HARKIN. In real dollars?

Mr. RINGEN. In real dollars.

That means that that Institute could not function effectively.

Other public health agencies shy away from workers' health issues. I know this, because of the 5 years that I spent at the National Institutes of Health, and saw the problems of trying to establish programs for workers.

Senator HARKIN. Was that the National Institute——

Mr. RINGEN. For Occupational Safety and Health—NIOSH.

Senator HARKIN. OK, go ahead.

I just wanted to get the right line, here.

Mr. RINGEN. In order to reinvigorate the Nation's programs dealing with workers, we need to get better coordination in the Federal Government and cooperation between Federal agencies and the private sector.

Three things need to be done in particular. First of all, designate NIOSH as the lead agency for workers' health, and to reinstate its budget.

Second, to require all other public health service units to develop plans for workers' health research and for cooperation with the National Institute for Occupational Safety and Health.

Third, to ask all public health service agencies to develop cooperative programs with private sector organizations that deal with workers' health, especially those that are organized under the rubric of labor-management cooperation.

On page 10 of my testimony, I have outlined specific recommendations with regard to this year's appropriations, that we would like to follow, and I will be happy to go through those with you. However, I think they are self-explanatory.

Senator **Harkin**. The recommendations are on page 10 here?

Mr. **Ringen**. Yes, sir.

Senator **Harkin**. Dr. Ringen, thank you.

Mr. **Ringen**. I hope you will give attention to this matter.

Senator **Harkin**. Well, do not worry. We are going to give plenty of attention to it.

Mr. **Ringen**. Thank you.

Senator **Harkin**. A lot of attention to it, and I have got all of the information here?

Mr. **Ringen**. I think so.

Senator **Harkin**. Of what you are asking.

I guess I am just—I do not know why it had not hit me before, but it is only one-third of what it was in 1981, even in real dollars?

Mr. **Ringen**. Yes; the recommended budget is at $40-some million now, the President's budget. The original NIOSH budget was close to $120 million.

Senator **Harkin**. Would it be correct to say that really what we are looking at here is basically research into preventative medicine?

PREPARED STATEMENT

Mr. **Ringen**. Absolutely. Preventing workplace risks is what NIOSH does, and it recommends standards to the Labor Department that it should implement to protect workers.

In effect, with this budget, you have dismantled that research effort.

Senator **Harkin**. Well, we will see what we can do about that.

Mr. **Ringen**. Thank you.

Senator **Harkin**. Thank you very much, Doctor.

[The statement follows:]

STATEMENT OF KNUT RINGEN

Thank you for allowing me to testify here on the need to reinvigorate the nation's programs of worker health within the Public Health Service.

My name is Knut Ringen. I am director of the National Health and Safety Fund of the Laborers' International Union of North America. I also am an adjunct member of the faculty of Mt. Sinai School of Medicine in New York, and a member of the faculty of the Graduate School of the National Institutes of Health. Before taking on my current positions, I was in charge of special populations research within the National Cancer Institute, NIH, for five years. I hold a Doctor of Public Health and a Master of Public Health from Johns Hopkins University, and a Master of Hospital Administration from the Medical College of Virginia.

I am testifying here on behalf of the more than 500,000 members represented by the Laborers International Union of North America (LIUNA) and the 2 million Americans who receive medical care insurance coverage from the 154 health and welfare funds operated by local LIUNA affiliates.

The Laborers' National Health and Safety Fund was formed in 1988 in response for the need to protect the health of LIUNA members and their families. The Fund is a joint initiative of LIUNA and a number of employer organizations, and it operates on the philosophy that improved health protection is in everyone's interest--workers, unions, employer and society. It is generally felt that health and safety should not be a subject of contention between labor and management.

There is no doubt that the Fund was organized in part in response to the Federal government abrogating its responsibilities toward American workers in the 1980s. The wholesale assault on the structures of labor relations and worker protection required responses. Thus, while the union and its signatory employers do more and more to protect the health of their workers, they find more and more how complex and deep-rooted many problems are. The health problems of workers in America cannot be addressed by labor and management alone, as the President's budget suggests. The federal government is, and always will be, an integral part of health protection for our working people, and its agencies must be directed to this end.

The Public Health Service is central to this, for without integrated research we will fail to progress on workers' health. The PHS has rightfully been characterized as a national treasure, albeit a treasure from which workers increasingly are excluded.

Background

The Health of Workers

Good health is not distributed randomly in the population. Figure 1 presents data from a cross-sectional standardized mortality survey of all occupational groups for white males ages 16-65 in California. As can be noted, teachers and physicians have standardized mortality rates (SMRs) which are close to 50% below the statewide average, while laborers, roofers, loggers and watermen have SMRs that are more than twice the statewide average and 5-6 times the rates for teachers or physicians. Indeed, those above the average fall neatly into the "blue" collar occupations, while those below are almost exclusively "white" collar. Laborers, for example, as presented in Table 1, have higher-than-average mortality rates for almost every cause of death. These data show that the average life expectancy for a laborer will be many years shorter than for a physician. This picture hardly agrees with the ideals of "equality" and "wellbeing" which we as a nation have cherished since independence.

In recent years we have not made progress on improving occupational health and safety statistics significantly. On the contrary:

- There is evidence to suggest that the rates of injuries and deaths from work-related causes among children are increasing.
- There is no evidence to suggest that cancer rates associated with occupational exposures are declining.
- Chronic pulmonary diseases, such as silicosis, remain the major occupational disease concern, as they have for centuries.
- Although injuries appear to be the most significant single contributor to the burden and costs of work-related ill-health, research on such injuries is inadequate, as are systems for monitoring of injury morbidity and mortality rates and patterns.
- Although injury and fatality rates in construction are alarmingly high, a systematic program of research to characterize the construction work environment has not been formulated.

The Magnitude of Work-Related Ill Health

Quantifying the magnitude of occupational ill health has historically been an endeavor fraught with difficulty. At the request of the New York State Legislature, in 1987 the Division of Environmental and Occupational Medicine at Mount Sinai School of Medicine completed an estimate entitled Occupational Disease in New York State. Based on the best available data and a consensus of scientific opinion about the fraction of major diseases, including cancers, pneumoconioses, chronic respiratory diseases, heart diseases, and renal diseases attributed to occupation, it was estimated that up to 6,600 deaths annually were due to work-related diseases.

When applied to cancer incidence, this estimate suggests that annually 6,580 new cases of cancer in New York state can be attributed to occupational exposures. Based on cost estimates from the 1975 Third National Cancer Survey, adjusted for inflation and the higher than national average costs of medical care in New York state, the medical care costs associated with these cancers are estimated at $205.7 million per year, and the value of foregone earnings $291.3 million. New York state contains slightly less than one-tenth of the national work force. Therefore, a crude extrapolation of these figures to the nation would indicate that some 65,000 new cases of cancer annually with annual costs of some $ 5 billion are attributable to occupation. This is a major national problem worthy of significant attention.

The total bill for premature disability and death is staggering. In 1980 the U.S. Department of Labor estimated that there are 1.88 million disabled workers in the U.S. Although it is difficult to estimate the economic cost of occupational disability, a Syracuse University study estimated the average costs for asbestos disability cases to the worker and his/her family of $475,000 and an additional $95,000 to society. This means a total cost per case to the victim and society in excess of $500,000. **If both of these estimates are correct, at present the total cost of occupational disability in the U.S. is approximately One Trillion Dollars.**

Workers Fall Between the Crack

Because of the labor contract, wage earners are bifurcated between life on the job and life off the job. The divided existence permeates all aspects of health. We speak of "occupational health risks" and "life-style health risks" as though they were completely separate. Occupational health services are completely separated from family medical care. Workers' Compensation is awarded only for injuries or diseases which clearly occur in the course of employment. The National Institute for Occupational Safety and Health (and OSHA) covers workplace risks; the other institutes and agencies cover non workplace issues.

This neat separation of work from everything else is good when it comes to establishing responsibility and accountability. It may even work for some aspects of health, such as injuries or acute illnesses. For the vast majority of today's diseases, however, this division denies workers the protection they should be entitled to.

Chronic disease and injuries creep up over a lifetime. They rarely have a single cause, and risks include those found on the job and off. Asbestos combines with smoking to cause lung disease, and solvents combine with alcohol in liver or kidney disease. Stress is hardly confined to the job or family life, but usually stress on one comes in combination with stress on the other, and usually a host of other factors, including substance abuse, enter into the picture.

The modern workplace is not neat, either. There is a lot of mobility within workplaces, between workplaces, and between occupations. Construction workers may change employers and job sites every month. The plant, which in the past may have produced a single product, now produces multiple. The construction site, which once may have been a very simple operation, today uses complex chemicals and mixtures and equipment.

A worker is a mover. He or she carries along risks from one workplace to the next, from one occupation to another, from workplace to community, and adds that mix to the genetic accumulation of generations.

The structures we have today simply are not right in terms of workers' health. They contribute to ill health. In today's complex society we need a more holistic approach. We need changes, and the federal government must lead.

The Downfall of Federal Programs

During the 1980s there has been stagnation or deterioration in a number of the occupational safety and health programs of the Federal government, including those of the Department of Health and Human Services:

- The budget and related activities as now proposed of the National Institute for Occupational Safety and Health have been reduced by two-thirds in absolute terms.
- Other agencies of the PUblic Health Service have similarly reduced their activities. The National Cancer Institute does not have a separate branch for occupational cancer prevention research, and the membership of the National Cancer Advisory Board does not appear to be constituted according to the congressional mandate (P.L. 95-622 (407)(a)(1)(B) to emphasize expertise in occupational and environmental carcinogenesis.

- Collaboration between the Secretary, Department of Health and Human Services and the Secretary, Department of Labor does not appear to function according to the intent of the Occupational Safety and Health Act. The scientific rationale for occupational safety and health is not being used by the Department of Labor.

- The support for research on occupational safety and health conducted extramurally under grants or contracts appears to have declined precipitously as a result of the severely reduced budget available to NIOSH for such purposes and the lack of support for such research within the general pool and specific programs of the National Institutes of Health.

- Collaboration between PHS agencies and organizations representing workers and employers with regard to occupational safety and health research and practice appears to have been de-emphasized with vigor.

The NIOSH Budget: A National Travesty

The National Institute for Occupational Safety and Health (NIOSH) should lead the nation in research and training on workers' health. NIOSH is especially critical to the health of the 40 million or so American workers who experience above-average death rates: the service worker, the farmer, the construction worker, the assembly line worker.

The President for FY 90 proposes to reduce the budget for the National Institute for Occupational Safety and Health to $44.57 million, which would be a 37 percent reduction from the FY 89 appropriation of $70.35 million. More importantly, this latest--and indeed unreasonable--attack, would leave NIOSH with an operating budget of less than one third of its FY 81 budget when controlling for inflation. At the proposed budget NIOSH could not function as a national institute, and even at its current level it cannot carry out its legislative mandate. In particular, limits in the budget for critical "discretionary" items, such as laboratory tests, computers, travel, etc are devastating the Institute. Extramural programs of research conducted by university groups cannot be funded: NIOSH has only about $ 1 million available to fund new extramural research each year.

As a result of these budget constraints many areas of research on workers' health have been neglected:

- Hazard assessments in agriculture, construction and services. We note that there still is no detailed industry-wide characterization of the hazards encountered by construction workers.

- We need many more on-site health hazard evaluations to address potentially imminent hazards in the workplace. Workers and most unions have no other source to obtain an impartial answer to possible health problems.

- Musculoskeletal disorders, including back injuries and cumulative problems like carpal tunnel syndrome, probably result in more disabilities, lost work time and medical care costs than any other causes. More research is needed on detection and treatment, including rehabilitation medicine.

- Early detection of diseases or exposures. The field of biomarkers and other early indicators is developing rapidly, and a maximum effort should be to research their application in workers. Workers can be identified as being high risk with great precision, which enhances the opportunity and need for this research.

- Workers who have been identified in past studies to have a high risk of occupational disease should be notified and offered assistance. At present large numbers of such workers are not given this basic benefit.

Injury Control

Injuries deprive workers of more years of life than any other cause. In 1985 the National Research Council, acting on a Congressional request, issued a report entitled Injury in America. 140,000 Americans die each year as a result of unintentional injuries; 80,000 are permanently disabled each year; and one in three Americans sustains a nonfatal injury of some significance each year. Injuries cause the loss of more working years than all forms of cancer and heart disease combined. Injuries cost our economy $ 75 to 100 billion per year in direct and indirect costs and contribute to inflation of health care costs. We also note that there are major difficulties in the Bureau of Labor Statistics reporting system for occupational injuries, and even for job fatalities. Two agencies are of particular significance to this problem and deserve special support: the Center for Injury Control, Centers for Disease Control, and the Division of Traumatic Injury Research, National Institute for Occupational Safety and Health.

Resource Development

To more adequately address the health needs of America's workers, it is vital that all resources available, public and private, be activated and better coordinated. The approach to this should be threefold.

First, the National Institute for Occupational Safety and Health should be formally designated the lead agency for occupational safety and health, with responsibility to mobilize and coordinate efforts to more vigorously address the health needs of workers.

Second, effective cooperation between the various public health service agencies needs to be created. At present, there is little cooperation between the Institutes of the National Institutes of Health and the National Institute for Occupational Safety and Health.

Third, we believe that the federal agencies concerned with this area should seek cooperation with private agencies and organizations to a greater extent that at present; in particular:

- Cooperative agreements should be established with joint labor-employer organizations which represent health and safety needs in a variety of areas: worker training, health insurance, membership/employee activities. These service delivery organizations can be a valuable source of research data and intervention experiments, as well.
- Fostering more training of professionals, including health workers in primary care, family medicine, and community health and social work about the need for occupational safety and health components in their practices.

The Need for Basic Oversight

It is more than 10 years since Congress conducted in-depth oversight hearings on the status of occupational safety and health in the Department of Health and Human Services' Public Health Service. Before determining its appropriations, Congress needs to conduct careful oversight of the Public Health Service. The following broad questions should be a guide:

- Whether all Public Health Service agencies are doing what they are authorized to do with regard to occupational safety and health;
- Whether collaboration with worker and employer organizations is being attempted to maximize the effectiveness of the nation's effort to curtail the burden of work-related ill health in the United States;
- Whether the science that is developed in the research community is being transmitted as effectively as possible to the service delivery, prevention and control communities.

Recommendations

1. The National Institute for Occupational Safety and Health. Designate NIOSH the lead Federal agency among public and private agencies and organizations interested in occupational safety and health research, training and education. Attached is the AFL-CIO's proposed budget for NIOSH for FY 1990 of $ 82.873 million and 900 full-time equivalent positions (FTEs). We support this budget.

2. The Assistant Secretary for Health. Appropriate $ 1.2 Million for demonstration programs to implement the recommendations of the U.S. Preventive Services Task Force in occupational groups with higher-than-average death rates. The report of the Task Force does not discuss such groups at all.

3. The National Institutes of Health. Direct all Institutes to develop plans for research on the health of workers, and to initiate collaborative programs with the National Institute for Occupational Safety and Health, and union and employer groups.

4. The Centers for Disease Control.

   (a) Chronic Diseases. Appropriate $ 1.5 Million for health promotion projects conducted by joint union-employer health programs.

   (b) Injury Control. Increase budget to $ 50 Million and 150 FTEs, of which $ 5.1 M and 13 FTEs will augment NIOSH's injury control research budget.

5. The Health Resources and Service Administration.

   (a) Appropriate $ 2 Million for joint union-employer demonstration programs directed at membership/employee assistance to deal with workers' health needs.

   (b) Increase from three to seven the number of grants for training programs in family and community medicine that include occupational and environmental health emphasis.

   (c) Establish a program of training grants for schools of social work focusing on workers' health.

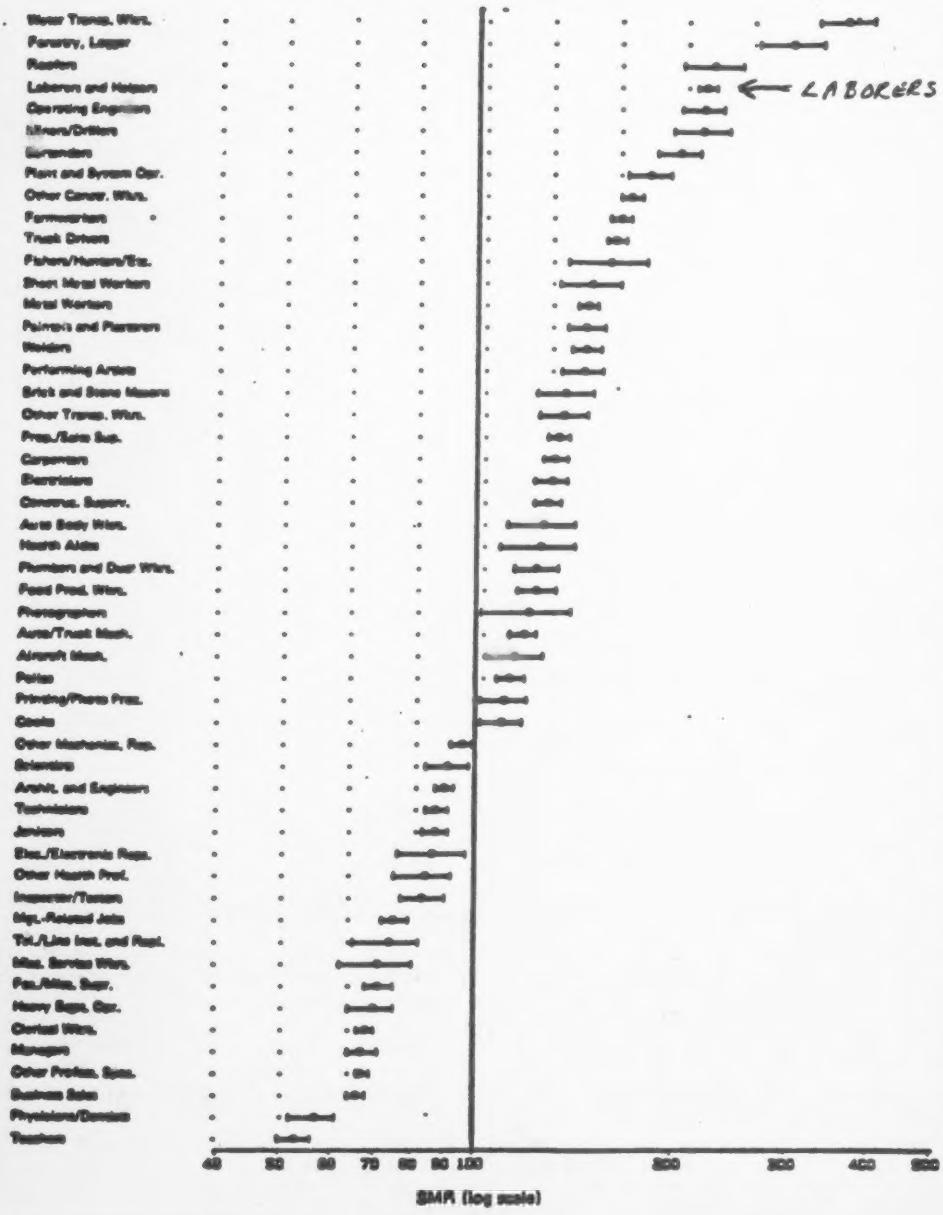
Attachments

1. Figure 1: Death Rates by Occupation in California.
2. Table 1: California Death Statistics for Helpers and Laborers.
3. Table 2: Recommended NIOSH Budget for FY 90.

Figure 1

Death Rates in California by Occupation

SMRs WITH INTERVAL ESTIMATES ENTIRELY
GREATER THAN OR LESS THAN 100
FOR ALL CAUSES OF DEATH BY OCCUPATION
CALIFORNIA 1979–1981
WHITE MALES



Source: State of California, Department of Health Services, Health Data and Statistics Branch, Occupational Mortality Study File.

Table 1

California Death Statistics 1979-81

Helpers and Laborers' -- Excess Deaths (Men ages 16-64)

	Death Index (California State = 100) *	
	White	Black
All Causes	225	317
Hypertension	244	252
Heart	148	266
Circulatory	196	320
Stroke	187	320
Cancer		
---Lip and Mouth	218	575
---Stomach	231	523
---Urinary	243	329
---Digestive	168	
---Lung	167	290
---Other	187	332
Chronic Lung Disease	267	325
Cirrosis	323	393
Falls and Machine Injuries	245	367
Other Accidents	251	312
Suicide	230	352
All Other	330	337

Source: Kizer, K.W., Kittler, A., Mitchell, D.W., Lera, G., Doebbert, G., California Occupational Mortality 1979-81, Sacramento: California Department of Health Services, March 1987.

*NOTE: These are percentages above the average (=100) death rate for adult men, by occupational category. For example, for all causes, white helpers and laborers experience 225 percent more mortality than the average working male in California.

Table 2

AFL-CIO Proposal for NIOSH Budget for 1990

Intramural Research	FY 1989 (in thousands of dollars)	Proposed FY 1990
Identification:		
Surveillance	$ 6,900	$ 8,000
Health Hazard Evaluation/ Technical Assistance	8,600	10,000
Targeted Research:		
Occupational Lung Diseases	6,523	6,523
Musculoskeletal Injuries	1,300	2,300
Occupational Cancers	3,650	3,650
Severe Occupational Traumatic Injuries	735	1,500
Occupationally Related Cardiovascular Diseases	330	330
Disorders of Reproduction	1,850	1,850
Neurotoxic Disorders	885	885
Noise-Induced Loss of Hearing	385	750
Dermatologic Conditions	315	315
Psychologic Disorders	675	675
Control and Personal Protective Equipment	7,985	8,500
Dissemination	6,927	8,500
Subtotal	47,060	53,778

Extramural Research	FY 1989 (in thousands of dollars)	FY 1990
Identification:		
Surveillance	1,400	3,000
Health Hazard Evaluation/ Technical Assistance	300	1,000
Targeted Research:	7,900	14,000
Control and Personal Protective Equipment	2,100	
Dissemination	1,500	1,500
Subtotal	13,200	19,500
Training	10,095	10,095
TOTAL BUDGET	70,355	82,873
Full-Time Equivalents	816	900

STATEMENT OF RICHARD FREEMAN, INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

ACCOMPANIED BY:

LISA SPRAGUE, CHAMBER OF COMMERCE OF THE UNITED STATES

JAMES ELLENBERGER, AFL-CIO

Senator HARKIN. Next is Richard Freeman, Interstate Conference of Employment Security Agencies, accompanied by Robert Martin, Chamber of Commerce of the United States, and James Ellenberger, AFL-CIO.

Before we start—can I just prevail a little bit on the patience of the people who are here?

We are always happy, especially since I am the father of two young children, when young people come to visit the Nation's Capital to see their Government in action.

Visiting us today is Ms. Mitchell's fifth grade class from Whetstone Elementary School in Gaithersburg, MD.

I understand they have a busy schedule and cannot stay long, but they are all in the back of the room.

We welcome you here to the committee, and as your teacher will tell you, what we are about today is studying how much of your parents' tax dollars will go to such agencies as the National Institute of Health for medical research into all kinds of illnesses that might affect you at some point in your future, or affect your friends and your neighbors.

So, to the fifth grade class of Whetstone Elementary School, welcome to the subcommittee. We are glad to have you here.

[Applause.]

Now, I will ask Mr. Freeman, from my home State of Iowa, to proceed with his remarks.

Thank you very much for being at the subcommittee today.

Mr. FREEMAN. Good morning, Senator Harkin and Senator Hatfield.

My name is Dick Freeman, and I am president of the Interstate Conference of Employment Security Agencies, and director of the Iowa Department of Employment Services.

I am joined today by Lisa Sprague, of the U.S. Chamber of Commerce, and Jim Ellenberger of the AFL-CIO, in a unique partnership to present our views concerning the fiscal year 1990 appropriations for employment security programs.

Over the last 7 budget years, the employment security system has suffered severe budget reductions which have resulted in fewer locations in which unemployment claims can be filed and employment services obtained, as well as a reduction in the types of employment services offered.

Employers, workers, and administrators are all concerned about this decline in services. The level of Federal funds has reached the point that many States have been forced to supplement Federal funds with State funds in order to operate our programs.

Many States have appropriated State general funds. A growing number are enacting State payroll taxes for unemployment insurance and employment service administration.

Employers, and ultimately the public, are paying twice for employment security services in this State.

Senator, in our State, employers will pay an additional $5.4 million in support of our job service offices as a result of a special surtax. This is in spite of the fact that they have already been taxed at a level adequate enough to support our operations.

An Interstate Conference survey shows that 35 States expect to spend approximately $140 million in State funds for employment security programs in fiscal year 1989.

Once again, Mr. Chairman, the administration's budget request would further reduce the 1989 program year funding level by nearly $72 million. The impact of such reduction would be devastating. Offices would be closed in urban and especially in rural areas, staff further reduced, and services curtailed.

Last year, the Congress provided supplemental funds to avert office closings and stabilize the system. We request your support for Wagner-Peyser funding that will replace on an incremental basis a portion of employment service staff that have been cut over the past 7 years.

The current staff level of approximately 15,000, less than one-half the 1982 level, is totally inadequate to meet the needs for services. Additional resources this year and in succeeding years will permit the States to reach a national staffing level of 20,000, an increase of nearly 5,000 from our present level.

In addition, the system desperately needs earmarked funds to improve its capacity to serve job seekers and employers through automation; 21 percent of all local employment service offices are either marginally automated or have no capability in this area, and 9 percent of all local offices are without terminals for use by employment service interviewers.

The system needs these earmarked funds to improve services through automation. We are requesting $25 million in program year 1990 to begin this process.

We also urge you to reject the adminstration's request to cut unemployment insurance base staff by over 1,000 jobs. This cut is not justified by lower levels of unemployment. It would merely replace trained workers, which the system badly needs to retain, with lower-paid, temporary staff.

Labor market information is an increasingly important component of the employment security system. We request that fiscal year 1990 funding for labor market information, under JTPA, title IV-D, be increased from the President's request of $4.4 million to $7.5 million, in order to produce adequate occupational data for substate areas.

We also support the administration's budget request for the Bureau of Labor Statistics, which is at $2.4 to $2.3 million for fiscal year 1990.

I also have a letter for you from the International Association of Personnel Employment Security and the Employers' National Job Service Committee, supporting our testimony, that I would like to submit for the record.

The Employers' National Committee is made up of 30,000 businessmen and women who volunteer their time to improve the effectiveness of employment security programs. The 24,000 members of IAPS are professionals working in unemployment insurance, employment service, labor market information, and the employment training programs throughout the world.

PREPARED STATEMENT

Senator, thank you for this opportunity to present our views. After Lisa and Jim speak, we will be pleased to respond to any questions that you or other members of the subcommittee may have concerning these programs.

Senator HARKIN. Thank you very much, Dick.

[The statement follows:]

STATEMENT OF RICHARD G. FREEMAN

Mr. Chairman, members of the Subcommittee, my name is Dick Freeman. I am President of the Interstate Conference of Employment Security Agencies, Inc. (ICESA) and Director of the Iowa Department of Employment Services. I am joined today by Bob Martin of the U.S. Chamber of Commerce and Jim Ellenberger of the AFL-CIO in a unique partnership to present our views concerning FY 1990 appropriations for Employment Security programs.

Over the last seven budget years, the employment security system has suffered severe budget reductions, which have resulted in fewer locations where unemployment claims can be filed and employment services obtained, as well as a reduction in the types of employment services offered. Employers, workers and administrators are all concerned about this decline in services.

As you know, federal unemployment taxes are imposed on employers to pay for the normal administration of unemployment insurance and employment service programs. These are not general revenue funds, and their use is legislatively restricted to the purpose for which they are imposed. In FY 1989, the Department of Labor estimates that $930 million (M) more will be collected under the Federal Unemployment Tax Act (FUTA) for employment security administration than will be expended. In FY 1990 the Administration estimates FUTA revenues at $3.65 billion (B) but only requests $2.69B to administer the employment security system--$960M less than FUTA revenues. It is difficult for employers, workers and administrators to understand why the employment security system must face continued reductions when the federal government expects to collect $960M more in federal unemployment taxes in FY 1990 than the Administration plans to spend for employment security programs.

There may always be disagreements between the states and the Secretary of Labor about the amount of funds necessary to administer properly and efficiently unemployment compensation laws and provide public employment services; however, the level of federal funds has reached the point that many states have been forced to supplement federal funds with state funds in order to operate unemployment insurance (UI), employment service (ES) and labor market information (LMI) programs. Some states have appropriated state general funds; a growing number are enacting state payroll taxes for UI and ES administration. Employers and, ultimately, the public are paying twice for employment security services in these states. Mr. Chairman, in Iowa, employers will pay an additional $5.4M in support of our Job Service offices as a result of a special surtax. This is in spite of the fact that they have already been taxed at a level adequate enough to support our operations.

ICESA recently surveyed states to determine how many are using state funds to supplement federal funds for employment security programs. The survey showed that 35 states expect to spend $140M in state funds for employment security programs in FY 1989. This is a very recent phenomenon in the 53-year history of this country's employment security system. The taxing authority and responsibility for funding rest at the federal level. Unless these arrangements are altered, states should not be forced to raise additional revenues in order to maintain services for which the federal government has already imposed a payroll tax.

States know that they are, in effect, letting the federal government off the hook by providing state funds to keep programs operating at a level that meets minimum state needs. The alternative is to operate an employment security system that is simply not acceptable to the employers and workers of the state.

The following outline describes in more detail the financial situation of employment security programs.

Employment Service

Once again, Mr. Chairman, the Administration's budget request would further reduce the ability of State Employment Service Agencies to meet the employment needs of our nation's jobseekers and employers. Specifically, it would reduce the 1989 program year funding level ($763.8M) by nearly $72M. The impact of such a reduction would be devastating: offices would be closed in urban and especially rural areas; staff further reduced; and services curtailed.

Last year, the Congress provided supplemental funds to avert office closings and stabilize the system. We request your support for a level of funding in Program Year 1990 that will keep offices open, shore-up essential services and begin investment in automation.

We request your support for funding that will replace, on an incremental basis, a portion of employment service staff that have been cut over the past seven years. The current staff level of approximately 15,000, less than half the 1982 level, is totally inadequate to meet the need for services. Additional resources this year and in succeeding years would permit the states to reach a national staffing level of 20,000; an increase of nearly 5,000 from our present level.

In addition, the system desperately needs earmarked funds to improve its capacity to serve jobseekers and employers through automation. A recent survey of our members clearly reveals the severity of this situation. For example, only 21 percent of all local ES offices are either marginally automated or have no capability in this area whatsoever and 9 percent of all local offices are without terminals for use by Employment Service interviewers. The system needs these earmarked funds to improve services through automation. We request $25M in Program Year 1990 to begin this process.

Unemployment Insurance

The Administration's request for unemployment insurance operations would provide for the increased cost of doing business but would reduce base/permanent staffing levels by over 1,000 jobs. The great strength of the unemployment insurance system is its ability to expand and contract in direct response to the business cycle. There is a minimum level, however, below which the system does not retain enough experienced staff from which to expand when unemployment goes up. We believe that many states are at or below that level now.

We urge you to reject the Administration's request to cut UI base/permanent staff by over 1,000 jobs. This cut is not justified by lower levels of unemployment (insured unemployment is expected to remain at the same level in FY 1990 as it is in FY 1989). It would merely replace trained workers, which the system badly needs to retain, with lower paid temporary staff.

Labor Market Information

Labor market information is an increasingly important component of the employment security system, which is funded through a variety of programs. Funds for gathering key occupational and employment data have been curtailed over the last several years. We request that FY 1990 funding for labor market information under JTPA Title IV, D be increased from the President's request of $4.4M to $7.5M, in order to produce adequate occupational data for substate areas.

We also support the Administration's budget request for the Bureau of Labor Statistics ($242.3M for FY 1990).

Conclusion

Mr. Chairman, thank you for this opportunity to present our views. We would be pleased to respond to any questions that you or other members of the Subcommittee may have concerning these programs.

STATEMENT OF LISA SPRAGUE

Senator HARKIN. Do you have something you wanted to add, just briefly?

Ms. SPRAGUE. Please.

I am Lisa Sprague. Robert Martin, who was to testify this morning, was unable to be here, because of a family emergency.

On his behalf, and on behalf of the U.S. Chamber of Commerce, I would just like to say that we heartily concur in the ICESA statement.

I might add that we are particularly concerned about the double tax situation, where States are forced to enact new taxes to provide services for which employers have already paid Federal tax.

As Mr. Freeman noted, this means that employers and ultimately the public are buying the same services twice.

STATEMENT OF JAMES ELLENBERGER, AFL-CIO

Mr. ELLENBERGER. Mr. Chairman, it might be a little unusual for you to have a panel that contains representatives from the Chamber of Commerce and the AFL-CIO.

I have a prepared statement in support of the testimony of ICESA, which I would ask be entered into the record.

I would just like to add to that that working people and employers have supported this unemployment insurance system, established 54 years ago, in many, many fashions, and this is not the first time that we have agreed on subjects involving unemployment insurance.

We are faced with a very serious problem in terms of administrative financing of this system, that I believe you and Senator Hatfield are familiar with.

We represent, as trade unions, people on both sides of the claims counter—claimants who are unemployed, and people who work within the system.

Senator Harkin, in your own State, the American Federation of State, County, and Municipal Employees represents the people in the Employment Security Agency in that State. Senator Hatfield, the Service Employees' International Union represents the employees in your State.

This is an issue of grave concern to everyone involved in unemployment insurance and the Job Service. From the Governors, through the Governors Association, as well as the National Council of State Legislatures, which is meeting in the Assembly of the Legislature here in Washington, DC, this week, and Senator Larry Hill, from the Oregon State Senate, is present this morning in this chamber.

PREPARED STATEMENT

He, as other legislators around the country, are terribly concerned about this problem and the dilemma that faces them in trying to find funds to pay for something that has already in essence and in reality been paid for.

Thank you.

[The statement follows:]

STATEMENT OF JAMES N. ELLENBERGER

Mr. Chairman, the AFL-CIO welcomes the opportunity to appear jointly before this Subcommittee with representatives of the Interstate Conference of Employment Security Agencies (ICESA) and the U.S. Chamber of Commerce. The AFL-CIO is in full support of the views presented here by Mr. Richard Freeman, President of ICESA, and would like to make this additional statement in support of more adequate funding levels for the operation of our nation's employment security system.

The AFL-CIO, as a national organization and through our state labor bodies, is in the unique position of representing not only the unemployed and those seeking counseling and job referrals through the employment service, but we also represent, through several of our affiliated unions, thousands of workers employed in this nation's employment security system.

Working people on both sides of the claims counter and the employment service desk have suffered due to underfunding of the system. This underfunding has occurred in both benefit trust funds and administrative financing. Heavy demands on the benefit trust funds in the late 1970s and early 1980s underlined the grossly inadequate funding of state benefit accounts and helped trigger additional reductions in the availability and adequacy of benefits through new restrictions in federal and state law. In a report issued last September, the General Accounting Office concluded that current federal policy has failed to encourage the buildup of adequate reserves in state unemployment insurance benefit trust funds. The GAO found that between 1981 and 1987, 44 jurisdictions, 28 of which had borrowed federal funds, took actions that reduced benefit recipiency.

These cutbacks have had a disastrous effect on the unemployed. Since 1984, just a third or fewer of the jobless have received benefits through the nation's unemployment insurance system. Two out of every three jobless workers did not receive the support this program ought to provide.

Similarly, during the recent period of the highest sustained joblessness in this country in the post-World War II period, we have witnessed tremendous cutbacks and reductions in the funding of the administration of our unemployment insurance and job service systems. Thousands of jobs have been eliminated and hundreds of job service and unemployment insurance offices have had to shut their doors since 1981. These unfortunate and tragic actions have occurred at the very time our political and economic leaders have been citing the need for more training and more flexibility in job adjustment.

It is difficult to accurately depict and relate the human costs stemming from such cutbacks in access to benefits and services. There are thousands who have had to stand in long lines to file an unemployment insurance claim (including those who have had their claim rejected due to more stringent qualifying requirements), or who have had to drive for hours to visit the nearest job service office because the one in or near their hometown was closed due to "budgetary" reasons. Failure to furnish such essential services adds to the ranks of the jobless. Such costs to our society of unemployment cannot be measured in mere monetary amounts; we must recognize the costs to our fellow citizens in terms of lost opportunities, wasted human potential, increased poverty, crime and destitution.

As you are aware, under the system established by the Social Security Act and the Federal Unemployment Tax Act (FUTA), states raise revenues for unemployment benefits and the federal government raises revenues for financing both the federal and the state administration of the system. Money raised by the federal government for this purpose is paid into the Employment Security Administration Account (ESAA), a dedicated trust fund. The federal government then pays out to the states, on a formula basis, funds to support the administration of the UI program. With such a low percentage of the jobless receiving benefits, the formula has resulted in declining federal support for the administration of a declining UI system. Even though the amount being collected in the ESAA is adequate to fund the various state systems, the combination of declining coverage of the unemployed and the inappropriate inclusion of the ESAA trust fund under the Gramm-Rudman deficit reduction program has resulted in serious underfunding of the UI and Job Service programs. The irony is that while the balance in the ESAA is increasing, the surplus in that fund can only serve as a "paper off-set" to the overall federal deficit because those funds are not available for any purpose other than state administration of the employment security program.

The cutbacks and budget reductions in the funding for administration of the unemployment insurance and job service system have encouraged proposals for a "devolution" or a defederalization of the funding of the administrative costs of the employment security system. The nation's employment security system functions to ameliorate, distribute and spread the costs of unemployment throughout our society on a more equitable basis. Adoption of any form of defederalization or devolution will hamper the ability of an individual state to cope with high levels of unemployment.

The consequences of both inadequate coverage of the unemployed by the system and inadequate federal funding of the administration of our employment security system are that when the next recession comes -- as it surely will -- workers will suffer and the economy will lack one of this nation's most important countercyclical stimulus programs. This situation was the subject of a front page article in the April 17, 1989 Wall Street Journal, "If a Recession Hits, Is U.S. Prepared for It?" which is attached to this statement. The article specifically focused on the inadequacy of the UI system to deal with the next recession and concluded that the unemployment compensation system "is supposed to provide a cushion to families of workers who lost their jobs. But for some workers, the cushion won't be there when the next recession hits."

The AFL-CIO supports a strong and effective federal role in the nation's employment security system. We urge the Congress to use the funds that are already available to improve and expand services offered by this essential program which are vitally needed by the unemployed. Working people and employers have a right to expect that the system be funded at levels that are appropriate to the tasks that federal and state laws require. All of us should recognize that funds spent in this effort are not costs but investments in our most important assets, the workers of this nation.

Thank you.

Attachment

[From the Wall Street Journal, Apr. 17, 1989]

The Outlook

If a Recession Hits, Is U.S. Prepared for It?

WASHINGTON

The U.S. may be about as well prepared for the next recession as Exxon was for the Valdez oil spill.

It's none too soon to begin reviewing economic contingency plans. After a year of steadily rising interest rates, signs of a slowing economy abound. Half the 50 economists surveyed regularly by the Blue Chip Economic Indicators now anticipate a recession late this year or early next.

The betting is that any downturn will be mild. But economists' track record in forecasting the severity of oncoming recessions hardly inspires confidence.

Because of changes in both the economy and government policy in the past decade, the next recession could be particularly painful. The borrowing binge by American corporations may make them especially vulnerable. The weakened social safety net may fail to catch some human victims. The intractable federal deficit may rule out a quick government rescue of the economy.

Among the most remarkable changes in the U.S. economy since the 1981-82 recession is the increasing propensity of American business to borrow—from banks, junk-bond markets and foreign investors. In this the seventh year of expansion, interest payments are claiming as big a fraction of corporate cash flow—of net income plus depreciation—as they did in the worst year of the last recession. The prospects of an economic slowdown don't seem to curb businessmen's appetite for debt.

"Our businesses are now unusually dependent on sustained continued growth of earnings to meet their debt obligations," says Harvard University economist Benjamin Friedman.

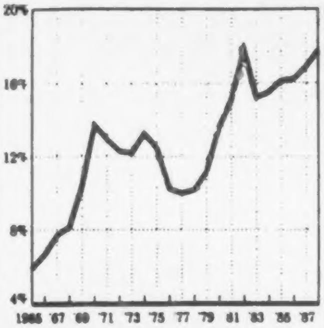
The problem, of course, is that cash flow and profit grow slowly, at best, in a recession; generally, they decline. Unable to service their debts, some companies will crumble. A recession as severe as that in 1981-82 could easily double the number of corporate bankruptcy filings, says Robert Litan, a Brookings Institution economist.

So what? some economists ask. As the past several years demonstrate, "Bankruptcy isn't the end of the world," Mr. Litan says. But a wave of bankruptcies involving big names in American business could jolt banks and financial markets—and the effects could cascade throughout the economy. "We don't have any way of knowing what the psychological effect would be," Mr. Litan admits.

About as far away from the bond market as one can get—at unemployment offices across the country—a different threat exists. To individual Americans, the unemployment-compensation system is the single biggest part of the government's contingency plan. It is supposed to provide a cushion to families of workers who lose their jobs. But for some workers, the cushion won't be there when the next recession hits.

Growing Interest Burden

Interest as a fraction of corporate cash flow



Source: Commerce Department

For a variety of reasons, including tightening of eligibility rules during the Reagan years and a shift away from manufacturing jobs, only 31.5% of all unemployed people collected jobless benefits last year, the lowest level in the 33 years for which data are available. That doesn't make headlines when the unemployment rate is at a 15-year low, as it is now. It will when the next recession arrives.

"We would start a recession with, in historical terms, the weakest unemployment-compensation safety net," says Robert Greenstein of the Center for Budget and Policy Priorities, a liberal advocacy group. A handful of congressmen have been proposing reforms, but they have made little headway. "This is exactly the right time to make unemployment insurance more reliable, more responsible and more effective . . . instead of patching up the system when an emergency presents itself," Rep. William Clinger, a Pennsylvania Democrat, says.

In past recessions, the government moved promptly to ease the pain by providing extra jobless pay for hard-hit parts of the country. But that's exactly the kind of spending that the current preoccupation with the federal deficit prohibits. The deficit, of course, would grow in a recession even without new spending measures; the cost of the thrift-industry rescue alone would add billions. In a recession as deep as the last one, many in Congress might well become far less concerned about the federal deficit, but that change in attitude might come too late for fiscal policy to help.

"The risk that policy paralysis could deepen a recession cannot be dismissed," Mr. Litan says.

Recessions are inevitable, and the resilient American economy will survive another one. Prudent precautions can control the damage—but only if they are taken.

—David Wessel

Senator **Harkin**. Let me just understand this.

Federal unemployment tax, the FUTA taxes that we pay, that goes into a trust fund, right? Is that a trust fund account?

Mr. **Freeman**. That goes into the administrative trust fund, yes. The employment security administrative account.

Senator **Harkin**. Dick, you said that in fiscal year 1989, the department estimates that $930 million more will be collected than will be expended?

Mr. **Freeman**. That is correct.

Senator **Harkin**. So evidently I see what is happening—it is another case where a trust fund is being used to offset——

Mr. **Freeman**. That is a correct assessment.

Senator **Harkin**. I see, I see.

This is one that I had not focused on before.

Did you have—I have a copy of your testimony, and yours.

Do you have testimony? I did not get Mr. Martin's. Do you know if he had testimony, or do we have a copy of it?

I may just be missing it. I will get it.

Ms. **Sprague**. I can certainly——

Senator **Harkin**. Well, I just want to put them all three together. I just did not have Mr. Martin's testimony.

I do not have any questions.

Thank you very much.

Senator **Hatfield**. Mr. Chairman, may I just speak a moment or two to the record here?

Mr. Chairman, this is another example of the fradulent manner in which we put together a budget resolution, to not only mislead the pubic but to mislead ourselves into believing that we have certain statistics that would prove that we have reached certain goals of budget deficit reduction.

Because we are using these trust funds to offset the true deficit, if we were but honest enough to set it forth. We, on the Appropriations Committee, are often accused of having turf competition with the Budget Committee, but that is far from being true, because we on the Appropriations Committee are circumscribed, limited, by the allocations under 302(b), by the matters of caps that are used in the budget resolution—and at the same time, we are presented here with ample evidence for the needs of various programs and the people.

It is indeed a frustration that I am sure you have sensed, because you are familiar with this process.

But I am deeply disturbed that we are increasingly using these trust funds that are paid by individuals for a specific program and for a specific purpose, and we are not only freezing those funds, or withholding those funds, but we are doing it in a way to try to mislead the public on the true character of the budget deficit.

The second point that I wish to make is that in this program, the focus has been a great deal on unemployed. Mr. Chairman, in our State at this moment, we happen to have an economic upturn, and this service is desperately needed, particularly by small business, to find employment for the business enterprise that is either expanding or trying to locate.

So I think that we ought to get the double purpose of this agency. It is not only to help find employment for the unemployed, but it is an attempt to serve business to find the type of employment that will permit that business to succeed and to expand.

Mr. Chairman, I would like to introduce State Senator Larry Hill from Oregon, because he has called on my office and brought me a memorial from the Oregon Legislature, and has outlined the problem as it specifically affects the State of Oregon.

He is here attending, as Jim has indicated, the national session of the legislative leaders. Larry, would you stand up and let the people see you? Thank you.

Mr. Chairman, I would ask unanimous consent that Senator Hill's letter to me outlining the impact in the State of Oregon along with the House Joint Memorial No. 2 that has passed the Oregon Legislature with an additional document be made part of our record here.

Senator HARKIN. Without objection. So ordered.

[The information follows:]

[LETTER FROM STATE SENATOR LARRY HILL]

The Honorable Mark O. Hatfield
United States Senator
711 Hart Senate Office Bldg.
Washington, D.C. 20510

May 10, 1989

Dear Senator Hatfield,

I would like to call your attention to an issue of vital concern to Oregon.

As you may be aware, the national Employment Security System has been underfunded for the past several years, even though adequate revenues to operate the system are being held by Congress in a dedicated trust fund which was created to fund the system.

Under the Social Security Act and the Federal Unemployment Tax Act (FUTA), states raise revenue from employers for financing both the federal and state administration of the Employment Security System. These FUTA funds are paid into the Employment Security Administration Account (ESAA). The ESAA is a dedicated trust fund which exists solely for the purposes of administering this system and receives no federal funds.

The surplus created by federal withholding of these dedicated revenues allows Congress to bring about the appearance of a reduction in the federal budget deficit, although these trust funds may not be used to actually reduce the deficit.

The impact on the states of the federal withholding of these funds has been severe. Since 1981, as a result of reductions in federal FUTA appropriations, Oregon has been forced to close one-third of the Employment Division field offices in our state and reduce staff levels by approximately 50%. Nationwide, these reductions have greatly diminished the effectiveness of the Employment Security System and its mission to respond to the needs of our labor force and business community.

The Oregon Legislature is currently working on a budget for the state Employment Division which will result in the closure of two employment offices, one in downtown Portland, the other in Redmond. The Legislature must also divert employer contributions from the state Unemployment Insurance trust fund to keep four other state employment offices open. Oregon has been forced to take this action as a direct result of federal witholding of FUTA funds.

In response to this situation, the 1989 Oregon Legislative Assembly has memorialized Congress to release adequate resources so that states can properly finance mandated Employment Security System programs. The Oregon Legislature has also called upon Congress to remove the FUTA Trust Fund from the unified federal budget and protect these funds from sequestration under the Gramm-Rudman-Hollings Deficit Reduction Act. I am enclosing a copy of 1989 House Joint Memorial 2 for your information.

In addition, the Labor Committee of the National Conference of State Legislatures (NCSL) adopted the attached resolution calling for proper federal administration of FUTA funds.

I would appreciate your support in correcting this funding dilemma so that we may assure that our national Employment Security System is strong and effective.

Sincerely,

LARRY HILL
State Senator

enclosures

65th OREGON LEGISLATIVE ASSEMBLY--1989 Regular Session

House Joint Memorial 2

Sponsored by Representatives DWYER, AGRONS, BAUM, BRIAN, CALHOON, CLARK, DIX, DOMINY, EDMUNSON, KEISLING, KOTULSKI, MANNIX, SAYLER, SHIPRACK, YOUNG, Senators BUNN, DUKES, KERANS, KINTIGH, SPRINGER, YIH

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Memorializes Congress to provide adequate funding for employment security programs administered by Employment Division of Department of Human Resources.

JOINT MEMORIAL

To the Senate and House of Representatives of the United States of America, in Congress assembled:

We, your memorialists, the Sixty-fifth Legislative Assembly of the State of Oregon, in legislative session assembled, respectfully represent as follows:

Whereas the level of federal funds allocated for administration of the Employment Security System nationwide, and the Oregon Employment Division in particular, has become increasingly insufficient; and

Whereas adequate funds are available for appropriation as a result of employer paid payroll taxes collected by the IRS pursuant to the Federal Unemployment Tax Act (FUTA) and which funds are dedicated solely to the administration of the Employment Security System; and

Whereas these dedicated and available resources have been made a part of the unified federal budget and are being withheld in order to mask the true size of the federal deficit; and

Whereas the Oregon Employment Division serves local populations, and the failure to release adequate administrative financing is significantly reducing its ability to provide the services to which the public is entitled; now, therefore,

Be It Resolved by the Legislative Assembly of the State of Oregon:

(1) The Congress of the United States is memorialized to promptly:

(a) Release adequate resources to properly finance the Employment Security programs and services the states are mandated to administer.

(b) Remove the dedicated FUTA trust fund money from the unified federal budget.

(c) Amend federal law so that FUTA dedicated trust fund money will no longer be subject to sequestration under the federal Gramm-Rudman-Hollings Act.

(2) A copy of this memorial shall be sent to the President of the United States and to each member of the Oregon Congressional Delegation.

NOTE: Matter in **bold face** in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted.

Employment Security System
Administrative Funding

Administrative funding for the Employment Security System is out of balance. Inadequate funding places state administrative systems under stress, resulting in deterioration of service on a nationwide basis

Under the framework of the system outlined in the Social Security Act and the Federal Unemployment Tax Act (FUTA), state revenues finance unemployment benefits while the federal government collects a payroll tax, levied upon employers, which provides funds dedicated solely to the administration of both the federal and the state systems. The amount now being collected is adequate to fund the various state systems, but the amount returned to the states has been shrinking because these funds are included in the federal unified budget and are also under the Gramm-Rudman-Hollings deficit reduction program. Consequently, the balance in these dedicated trust funds is increasing, serving only to mask the overall size of the federal deficit.

As a dedicated trust fund containing adequate resources, the Employment Security Administration Account is more than capable of adequately financing the Employment Security System nationwide and the NCSL, therefore, urges Congress to:

1. Release adequate resources to properly finance the Employment Security System nationwide.
2. Remove the dedicated FUTA trust fund money from the federal unified budget.
3. Amend federal law so that FUTA administrative money will no longer be subject to sequestration under the federal Gramm-Rudman-Hollings Act.

Senator Hatfield. I thank you, Mr. Chairman.

Senator Harkin. Thank you, Senator Hatfield.

Now, Lisa, what you were saying caught my ear. It is Lisa, right?

Ms. Sprague. Yes.

Senator Harkin. You said that because we are not spending the money out for this, the States have an additional burden?

Ms. Sprague. In order to keep the various components of the system running in their States, as opposed to just saying well, we will have to shut it all down, States are either, in some cases appropriating general revenues.

Senator Harkin. Yes; I understand.

Ms. Sprague. In some cases, enacting new payroll taxes, just to keep things going.

Senator **Harkin**. Do you have any data? Does the chamber have any data on this, where is it occurring around the country, any——

Ms. **Sprague**. I am sure we could put some together. I do not have——

Senator **Harkin**. Do you have something—does either one of you have any data on what is happening in the different States on that?

Mr. **Freeman**. Yes; we do, Senator, and as I remarked, we know that there are 35 States in this program year who are supplementing the Federal program to the tune of about $140 million, and that includes a surtax in our own State, Senator, of $5.4 million, just to keep our offices open in Iowa.

Senator **Harkin**. That is, as you said, money that has already really been paid?

Mr. **Freeman**. That is right, that is correct.

Senator **Harkin**. OK.

Thank you very much, Dick.

Mr. **Freeman**. Thank you very much for your time.

Senator **Harkin**. Are you Dr. Fuller?

Dr. **Fuller**. Yes.

Senator **Harkin**. Dr. Fuller, I am going to have to ask for your indulgence, if I might.

STATEMENT OF DR. WANDA BIGHAM, PRESIDENT, MARYCREST COLLEGE, DAVENPORT, IA

Senator **Harkin**. I have just been informed that Dr. Wanda Bigham, president of Marycrest College, representing the TRIO programs, needs to testify because she has to catch a plane.

Do you mind? You can go ahead and sit right there. She can sit right next to you, there. Come on up. You just sit right there.

Dr. Wanda Bigham, president of Marycrest College.

Dr. **Bigham**. Thank you, Chairman Harkin, and Senator Hatfield.

It is a pleasure to be here.

I am Wanda Bigham, president of Marycrest College in Davenport, IA. I am representing the TRIO programs, and requesting funding for programs for disadvantaged youth.

I speak to you as an individual whose first administrative position in higher education was the director of TRIO programs at Morehead State University in Kentucky. I was director of Upward Bound special services and Talent Search, and I had an opportunity during those years to see first hand how these programs serve disadvantaged youth.

I would like to take just a moment to tell you about the continuing need for services to disadvantaged youth, and the evidence of success of the TRIO programs, and to request funding during fiscal year 1990.

The TRIO programs were begun in the late 1960's to meet the need of assisting youth to graduate and to continue in higher education, to assist low-income youth.

Those programs have been quite successful. Nevertheless, the need continues. There has never been an opportunity to serve all of those who have need.

At this point, if we look at statistics, there is an indication that within the 18- to 24-year-old group, 13 percent of those are black youth; 10 percent of those go to higher education institutions, and only 6 percent of baccalaureate degrees go to minority youth—to black youth.

When one looks at the Hispanic picture, 9 percent of the youth in the ages 18 to 24 of Hispanic youth—only 6 percent go on to higher education, and only 3 percent receive their graduate degrees—their baccalaureate degrees.

TRIO programs make a difference in the graduation rates from high school and the continuation rates in college and in the graduation rates from college.

In the institution that I currently serve, we have an Upward Bound Program, and in the institution which I previously served we had all three of the TRIO programs.

Upward Bound graduates from both of the institutions I have served graduate and go on to colleges at a rate of 90 percent of Upward Bound seniors going on to colleges—a wonderful graduation rate.

Nationally, Upward Bound graduates are four times as likely to go to college as are their counterparts who did not receive Upward Bound assistance.

At the college level, special services participants are twice as likely to graduate.

I have watched in the colleges where I have served as whole families have been influenced by the spinoff from these programs.

I think right now of a family where one son in the family went to the Upward Bound Program and began to get the idea of going to college. Younger brothers and sisters soon began to make their plans for college, and did attend. Cousins began to attend, and on one beautiful occasion, a mother of that child said to me, "My husband is becoming increasingly disabled. Do you think I could go to college?" That woman is now a teacher, and her whole family has been influenced by the good that Upward Bound has done.

At the college that I serve now, Marycrest College, despite the fact that we are a struggling institution, we are trying to do our best for low-income students. We have made a commitment that we will reduce tuition by 50 percent for graduates of the Upward Bound and Talent Search Programs who come to Marycrest.

We have also set up a program for single parents on welfare or single parents from low-income backgrounds, to help to remove them from welfare rolls or from low-income situations.

We need the help of the Federal Government to assist us in providing the special services opportunities—the special services assistance that those individuals need and that we as an institution are unable to fund at the level that is appropriate for that.

Because there continues to be need, and because these programs are successful, we ask you to fund those programs at $265.5 million in fiscal year 1990.

PREPARED STATEMENT

I know you have many, many requests for your funds. But I can tell you that higher education makes a difference, and that higher education gives youth and young adults the opportunity to manage their own well-being.

These are important and successful programs. Do help us, please.

Thank you very much.

[The statement follows:]

STATEMENT DR. WANDA BIGHAM

Mr. Chairman, Members of the Subcommittee, I very much appreciate the opportunity to testify before the Subcommittee today. My name is Wanda Bigham and I am the President of Marycrest College in Davenport, Iowa. I am particularly pleased to be here testifying today on behalf of the TRIO Programs and the National Council of Educational Opportunity Associations because I began my career in higher education as Director of TRIO Programs at Morehead State University in Morehead, Kentucky and one of the professional achievements of which I am most proud is serving as the initial Treasurer of the National Council of Educational Opportunity Associations.

It is indeed a humbling experience to witness hearings before this Subcommittee. The needs represented by most, if not all of those appearing before you today, are real and pressing. The resources available to you are, within that context, so limited.

Many of the members of the Subcommittee are familiar, I am sure, with the 1988 report "One Third of a Nation" issued by the American Council on Education and the Education Commission of the States. That report is evidence of the commitment of college and university presidents, who, I believe, are committed to utilizing their institutions to further equity in this nation.

But I must admit that as a college president, most of the issues which cross my desk each day are more directly related to institutional survival, improvement and expansion than they are to this important national goal. It is for this reason that TRIO programs are so important on college campuses--not only do they bring low-income, minority and first-generation students to all categories of colleges and universities who would not otherwise be there--but they also bring advocates for those students to campus. And those advocates have been effective in ensuring that TRIO students once enrolled have a realistic opportunity to achieve a baccalaureate degree. TRIO programs, TRIO staff, TRIO students are an important presence on a campus--pressing an institution and indeed a college President to make real their commitment to equal opportunity.

Of course the figures document how crucial it is that we reverse the declines of the past decade. According to the "Seventh Annual Status Report on Minorities in Higher Education" published by the American Council on Education, minority enrollment and graduation rates continue to decline nationally. These declines are of particular concern because black students, and other students from disadvantaged backgrounds, are making up an increasing percentage of the population.

Data from ACE's Sixth and Seventh Status Reports when taken together paint a grim picture. Today, 13% of 18-24 year olds are black while 12% of 18-24 year old high school graduates are black. However, when it comes to attainment at the postsecondary level, the numbers fall off sharply. For example, only 10% of those enrolled in college today are black; only 6% of bachelors degrees conferred go to blacks; and only 4% of doctorates conferred are awarded to blacks.

The numbers for black males are even more alarming. 13% of 18-24 year old males are black but only 9% of the men enrolled in college are black. Moreover, only 4% of male bachelor degree recipients are black and only 2% of male doctorate recipients are black.

The record for Hispanics reflects similar disparities although the outcomes for Hispanic males and females are much more similar. Hispanics make up 9% of 18-24 year olds; 7% of 18-24 year old high school graduates; and 6% of those enrolled in college. However, thay receive only 3% of baccalaureate degrees conferred and only 2% of doctorates awarded.

Moreover, while in Davenport the problems of minorities are pressing, (for example, the dropout rate of minority students at Davenport Central is over 35%), the problems of white working class families in an economy in transition are being addressed by TRIO programs. 35% of TRIO students nationally are low-income or first generation white students. Senator Harkin, I know of your work and Senator Hollings' work in nutrition programs for poor children. From that work, you are more than familiar with the fact that the number of children in poverty has grown from 10.9 million in 1975 to 12.5 million in 1985. Moreover, the number of white children in poverty grew 16% over that period.

In Davenport since 1980, we have lost more than 18,000 jobs in farm implement manufacturing at Deere, International Harvester, J.I. Case and Caterpillar alone. Unless these workers and their children can be educated to assume a broader range of positions in a diversified economy, our region will necessarily decline. A vital educational system that reaches all young people and all adults in need of retraining is vital to the Quad Cities economy. TRIO programs have a specialized role in reaching persons with potential who would not ordinarily be served by higher education. For that reason, I hope that TRIO at Marycrest can be expanded from our present Upward Bound program to include Student Support Services and Talent Search as well. Only increased appropriations will allow such expansion.

A three part series "Unequal Opportunity--Higher Education in America" appeared in last week's Washington Post. It argued "higher education was once envisioned as the great equalizer in American society, providing anyone who was qualified with the credential that would redress inequalities in background and birth. Today the reality is far different. The nation's colleges and universities are sharply stratified by class and race, and for many students, entry to the upper echelon is as unlikely as membership in an exclusive club."

The author concludes "No one is suggesting that higher education abandon its method of grouping students by ability. But it is clear now that simply removing the most daunting economic and racial barriers to college is not enough when most low-income students emerge from high school unequipped to compete for entry into the nation's best colleges." While the Post article suggests that these are new realizations, Congress, since the mid-sixties, has recognized that financial aid alone is not sufficient to assure the policy goal of equal educational opportunity. Accordingly, it has provided strong and sustained support for the academic, instructional and counseling services provided by the TRIO programs.

My own experience at Marycrest and at Morehead State reflects the fact that financial aid--taken together with comprehensive support systems provided by the TRIO programs--can be successful in allowing students from the most disadvantaged segments of our society a realistic opportunity to complete a baccalaureate degree. For example, annually the Upward Bound program at Marycrest enrolls 60 ninth, tenth, eleventh and twelfth grade students from the Quad Cities. Each year we place over 90% of our Upward Bound graduates in college.

And our graduates are outstanding. Luis Jiminez, for example, a 1984 graduate of our program is presently finishing his senior year in Mechanical Engineering at the University of Iowa. Despite the fact that Luis was the first in his family to attend college, with the support of another TRIO program--Student Support Services at Iowa--he has been on the Dean's list for seven semesters. Moreover, he was instrumental in the founding of the first Hispanic national fraternity, Sigma Lambda Beta, which has as a principal purpose educating others within the college community regarding Hispanic culture. Mr. Jiminez also returns to work with current Upward Bound students at Marycrest on a regular basis.

The Bush Administration Supports Expansion of TRIO

As you are aware, the previous Administration did not see the necessity of federal support for intervention efforts such as TRIO and consistently recommended severe reductions in their appropriations. The present Administration--and in fact the final Reagan budget--included a recommended increase in TRIO funding. While the increase in funding recommended is not sufficient given increases in the number of low-income, first-generation students eligible for TRIO services, it is noteworthy.

Of similar note is the fact that the Administration is presently moving to extend TRIO services down through the junior high school level. Presently, most disadvantaged youngsters served by Talent Search or Upward Bound are not recruited until their junior year in high school. The Administration is planning to announce a special competition with Fiscal 1989 funds to allow Talent Search projects to begin serving seventh and eighth grade students as is permitted by the Talent Search authorizing language. This move is a recognition of the severe academic and attitudinal barriers presently facing youngsters from the most disadvantaged backgrounds.

TRIO Programs are Successful

Many members of your Subcommittee are familiar with TRIO's record of success. You are aware that a 1979 Research Triangle Institute Study of Upward Bound found that program graduates are four times as likely to graduate from college as similar students without benefit of Upward Bound. A 1981 Systems Development Corporation study of Student Support Services found that college freshmen served by this TRIO program are more than twice as likely to complete their freshman year as similar students who did not receive supplemental counseling, tutoring and instructional services.

The Administration has proposed updating this record of services with additional studies of the effectiveness of the TRIO programs. We agree with the need for such follow-up and welcome the Administraiton's interest in such data.

Recommendations Regarding Fiscal 1990 Funding

Mr. Harkin, Members of the Committee, Marycrest is a developing college. Our endowment includes only modest amounts for scholarships, our present enrollment is a headcount 2,700, a full-time enrollment of 1,050. However, given my experience with the TRIO programs, I know that they work, that they are consistent with the mission of our college, and that they are necessary to the good of Davenport, of Iowa and of the nation.

For that reason I have made the commitment that any Talent Search or Upward Bound student from any program in the country who meets minimum academic standards and chooses Marycrest will receive a 50% reduction in tuition. With the support of my faculty and staff, I have also put in place a program that covers the full cost of a dormitory room for any TRIO student nationally who meets a slightly higher academic cut-off. These commitments were made at some cost to Marycrest, but they were made because I saw no alternative.

NCEOA is asking for a similar commitment from the Subcommittee today. The NCEOA is recommending a funding level for TRIO programs of $265.5 million for Fiscal 1990. This would allow the programs to serve 577,000 students, an increase of approximately 15% over the 500,000 presently served as well as more rapid growth in the Ronald E. McNair Post-Baccalaureate Achievement Program which will be funded for the first time this summer. We recognize that this increase will also necessitate some cost to this Subcommittee, but very frankly, in view of declining enrollments of low-income, minority and first-generation students, we see no more cost-effective alternative for addressing the problem than more rapid investment in TRIO programs.

STUDENTS SERVED AND PROJECTS FUNDED BY TRIO APPROPRIATIONS

FY 1989

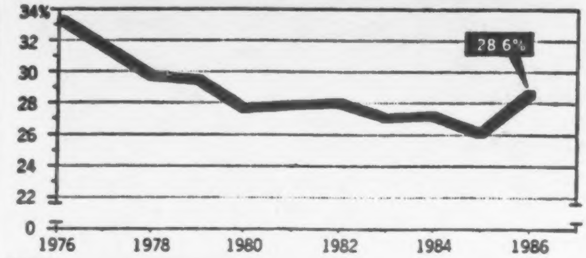
	DOLLARS	STUDENTS	PROJECTS
EOC	11.7 million	112,700	41
McNair Post-baccalaureate Program	1.5 million	900	15
Student Support Services	86.6 million	152,630	716
Talent Search	26.2 million	199,420	178
Upward Bound	92.0 million	34,390	435
Training	1.3 million	-	-
Total	219.3 million	500,040	1385

AMOUNT NEEDED TO ASSURE A 15% INCREASE IN THE NUMBER OF TRIO STUDENTS AND EXPANSION OF THE RONALD E. MCNAIR POST-BACCALAUREATE ACHIEVEMENT PROGRAM

	DOLLARS	STUDENTS	PROJECTS
EOC	14.0 million	129,600	41
McNair Post-baccalaureate Program	5.0 million	3,000	40
Student Support Services	103.7 million	175,520	716
Talent Search	31.4 million	229,330	178
Upward Bound	110.1 million	39,550	435
Training	1.3 million	-	-
Total	265.5 million	577,000	1410

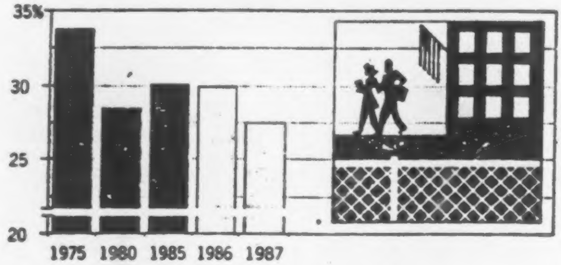
ADMINISTRATION RECOMMENDATIONS FOR FY 1990

	DOLLARS	STUDENTS	PROJECTS
EOC	12.1 million	112,040	41
McNair Post-baccalaureate Program	1.5 million	860	15
Student Support Services	89.5 million	151,440	716
Talent Search	27.1 million	197,810	178
Upward Bound	95.2 million	34,150	435
Training	1.3 million	-	-
Evaluation of TRIO Programs	1.5	-	-
Total	228.2 million	496,300	1385



THE PERCENTAGE OF BLACK HIGH SCHOOL GRADUATES ENROLLED IN COLLEGE IS DOWN...

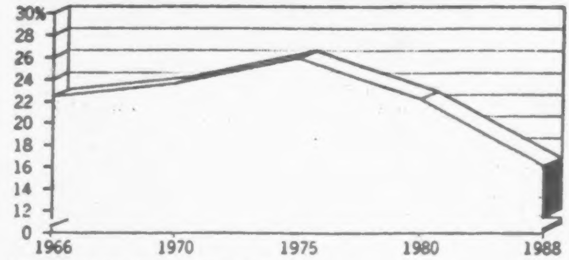
SOURCE: American Council on Education



POOR HIGH SCHOOL GRADUATES ARE LESS LIKELY TO ATTEND COLLEGE...

PERCENTAGE OF HIGH SCHOOL GRADUATES WITH AT LEAST ONE YEAR OF COLLEGE WHO LIVE AT OR BELOW THE POVERTY LINE

SOURCE: Children's Defense Fund, analyzing Census Bureau data



AND FEWER LOW- AND MIDDLE-INCOME STUDENTS ATTEND PRIVATE UNIVERSITIES TODAY

PERCENTAGE OF STUDENTS AT PRIVATE UNIVERSITIES WHOSE FAMILY INCOME IS AT OR BELOW MEDIAN INCOME

SOURCE: UCLA and American Council on Education

THE WASHINGTON POST

Table 1
High School Completion (1) and College Entrance Rates for Population 18–24 Years Old by Race/Ethnicity: United States, Selected Years
(Number in Thousands)

	1971	1976	1981	1985
Total:				
Total population 18-24-yr.-olds	23,668	26,919	28,965	27,122
Number completing high school	18,691	21,677	23,343	22,349
Number enrolled in college	6,210	7,181	7,575	7,537
H.S. graduates as a percentage of total	79.0%	80.5%	80.6%	82.4%
College entrants as a percentage of 18-24-yr.-old H.S. graduates	33.2%	33.1%	32.5%	33.7%
College entrants as a percentage of 18-24-yr.-old population	26.2%	26.7%	26.2%	27.8%
White:				
Total population white 18-24-yr.-olds	20,533	23,119	24,486	22,632
Number completing high school	16,693	19,045	20,123	18,916
Number enrolled in college	5,594	6,276	6,549	6,500
H.S. graduates as a percentage of total	81.3%	82.4%	82.2%	83.6%
College entrants as a percentage of 18-24-yr.-old H.S. graduates	33.5%	33.0%	32.5%	34.4%
College entrants as a percentage of 18-24-yr.-old population	27.2%	27.1%	26.7%	28.7%
Percentage of the total 18-24-yr.-old population	86.6%	85.9%	84.5%	83.4%
Black:				
Total population Black 18-24-yr.-olds	2,866	3,315	3,778	3,716
Number completing high school	1,789	2,239	2,678	2,810
Number enrolled in college	522	749	750	734
H.S. graduates as a percentage of total	62.4%	67.5%	70.9%	75.6%
College entrants as a percentage of 18-24-yr.-old H.S. graduates	29.2%	33.5%	28.0%	26.1%
College entrants as a percentage of 18-24-yr.-old population	18.2%	22.6%	19.9%	19.8%
Percentage of the total 18-24-yr.-old population	12.1%	12.3%	13.4%	13.7%
Hispanic(2):				
Total population Hispanic 18-24-yr.-olds	1,338	1,551	2,052	2,221
Number completing high school	694	862	1,144	1,396
Number enrolled in college	179	309	342	375
H.S. graduate as a percentage of total	51.9%	55.6%	55.8%	62.9%
College entrants as a percentage of 18-24-yr.-old H.S. graduates	25.8%	35.8%	29.8%	26.9%
College entrants as a percentage of 18-24-yr.-old population	13.4%	19.9%	16.6%	16.9%
Percentage of the total 18-24-yr.-old population	5.6%	5.7%	7.1%	8.2%

NOTES: (1) Since these high school completion rates were calculated by adding the numbers of individuals in this group enrolled in college as of October of that year and the number of high school graduates not enrolled in college, these rates include individuals who enrolled in college without receiving a high school diploma or a GED. Several states do not require entering junior college students to have a diploma or GED. Therefore, these high school completion rates will be slightly higher than figures that do not include this relatively small population.

(2) Hispanics may be of any race.

SOURCE: U.S. Department of Commerce. Bureau of the Census Current Population Reports. Series P-20, 247, 309, 373 and 409.

Senator **Harkin**. Thank you very much, Dr. Bigham, for being here, and for your testimony on the TRIO program.

I first saw the TRIO program 16 years ago at Graceland College, and became very enthused about it. I was there during the summer and saw the program there, and have been a great advocate of it ever since.

Certainly the things that you have talked about bear witness to the fact that it has been a very successful program.

I notice that as you know, the administration did ask for an increase—it looks to me about 5 percent—in the TRIO programs next year, with most of it going to the student support services, Talent Search, and Upward Bound.

Dr. **Bigham**. I have asked for funding above that, as you know. It is good preventive medicine.

Senator **Harkin**. It sure is.

Dr. **Bigham**. Thank you very much for hearing me.

Senator **Harkin**. Thank you very much.

Dr. **Bigham**. Thank you, Senator Hatfield.

Senator **Hatfield**. Dr. Bigham, thank you.

STATEMENT OF DR. VIVIAN L. FULLER, INDIANA UNIVERSITY OF PENNSYLVANIA NATIONAL COLLEGIATE ATHLETIC ASSOCIATION

Senator **Harkin**. Now we will come to Dr. Vivian Fuller, Indiana University of Pennsylvania, representing the National Collegiate Athletic Association.

Dr. **Fuller**. Good morning, Mr. Chairman and members of the subcommittee.

My name is Vivian Fuller, and I appreciate this opportunity to testify in support of an appropriation for the National Youth Sports Program of $8.743 million under the Community Service Grant Act, and $4 million under the Anti-Drug Abuse Act.

I have submitted a statement for your record, and this morning, I would just like to highlight a couple of key points.

I think one of the things that we can say especially that has been very rewarding to me is that we are all out here to help youth, and we have a lot of disadvantaged youth. But we also have a lot of strong leaders out there in the community who can serve these youth.

NYSP urgently needs additional funding. For 12 years Federal funding has remained flat in the face of sharply increasing operational costs and double-digit inflation. Despite substantial non-Federal contributions which greatly exceed the amount of Federal appropriations, the declining value of the Federal funding resulted in erosion of the services provided.

The number of projects conducted, needy youth served, and operating days all have declined. We started out operating with about 30 days, and now those programs have gone to about 25 days.

Congress has provided a modest increase in funding for the past 2 years, and we greatly appreciate that, but we still need more.

This is the fifth year that the salary ceiling in those programs has been in place. It is greatly impeding our ability to attract qualified instructors, and we urgently need to address the problem.

NYSP takes pride in the quality of its staff, many of whom are residents of the poverty target areas. All auxiliary staff and professional staff must have a college degree, and the medical coordinator must be licensed with the net program.

Beyond their professional credentials, most staff members are dedicated individuals who truly care about these youngsters and who go beyond the call of duty. Nonetheless, the salary ceiling has made it increasingly difficult to recruit and retain qualified staff.

For example, top NYSP professional staff salary has been frozen at about $15,000 annually, which translates to $250 to $300 per week. For individuals with college degrees and experience, these salaries simply are not competitive.

We also want to restore transportation to at least one-half of the projects which service poor neighborhoods previously served. Our CSBG appropriation request by no means represents the amount of need fully to restore lost services.

We are limiting our request in recognition of the constraints facing the subcommittee.

Last year, Congress provided $3 million in drug act funding to enhance the drug-abuse prevention component of NYSP.

One of the things that the national office is doing now is regional workshops, and going around to these States and seeing what they are doing with the drug education component.

We are finding out that we are going out to communities and we are doing some really outstanding things with our students.

This year, the amount of drug abuse prevention enriched instruction, which will be doubled in the summer program—we have hired a drug education specialist in each project. We are training drug education specialists and other project personnel, and we plan to operate a year-round program.

With our year-round program, we will be able to have contact with our youngsters not only during the summer, but also through the entire year.

Youngsters will go on a college campus, but they will not sign up for a drug education program or course. But if you use the avenue of sport to get them in, you can also teach some other things, like self-assertiveness and also self-confidence.

Of the 137 projects, we plan to have a year-round program with about 50 of those projects this year. Our request for $4 million will enable us to continue this work and to operate a year-round program at another 15 to 20 projects.

NYSP participants are key target populations for use of illegal drugs. These youngsters will be more enriched and more enhanced with the things that we can do in NYSP.

Because of the high level of non-Federal contributions, NYSP is a particularly cost-effective use of Federal dollars. It is a program with a 21-year record of success, and I know that you will be faced with tough choices when you make up this bill, but I urge you, and recommend the funding necessary for NYSP to continue for needy youth and do the part of fighting the war against drugs.

I guess one situation that comes in mind working in NYSP and being a counselor, and also coming through and being an activities director, is, after a 4-year span, seeing youngsters coming back and wanting to enroll in your college, or coming up to you and asking you for a recommendation, simply because you have had a chance to make an influence.

PREPARED STATEMENT

I think what we have to do with all the problems that are facing us in the Nation today is do whatever we can to help disadvantaged youth. I think NYSP has a history, and I think NYSP has the ability that we need to support to help our youth today.

Thank you.

[The statement follows:]

STATEMENT OF VIVIAN FULLER

Mr. Chairman and members of the Subcommittee, my name is Vivian L. Fuller. I am Associate Director of Intercollegiate Athletics at Indiana University of Pennsylvania and a member of the National Collegiate Athletic Association ("NCAA") National Youth Sports Program ("NYSP") Committee. Previously, I was Activity Director of the NYSP project at North Carolina A&T State University in Greensboro, North Carolina for two years, and a project aide in the NYSP project at Fayetteville State University in Fayetteville, North Carolina for four years. I appreciate this opportunity to testify in support of an appropriation of $8.743 million for the FY 1990 NYSP under the Community Services Block Grant ("CSBG") Act, and $4 million for the FY 1990 NYSP under the Anti-Drug Abuse Act of 1988.

Each summer for more than twenty years, NYSP has brought thousands of needy boys and girls, ages 10-16, over 90 percent of whom meet the HHS Poverty Income Guidelines, onto college campuses. There they receive a free medical examination and follow-up; free daily USDA-approved meals; and a daily enrichment program addressing such areas as drug and alcohol abuse prevention, health and nutrition, teen pregnancy prevention, AIDS, and educational and career opportunities. In addition, they receive high-quality instruction in competitive and lifetime sports. In 1988, 56,321 boys and girls participated in NYSP projects at 138 colleges and universities (30 percent of which are not NCAA members) in 116 cities in 41 states. Some 57,418 free medical examinations were performed and over 1.6 million U.S.D.A.-approved meals and supplements were served. Efforts are made to enroll "high risk" youth who can benefit most from NYSP. The program also provides summer employment for many residents of poverty target areas.

NYSP uses the medium of sports to attract and motivate needy youngsters to reach for and to achieve high goals and to pursue a college education. For most participants, NYSP is their first exposure to a college campus. Many NYSP instructors are past participants who provide positive role models. This constructive experience in the college environment helps to direct the energies of these economically disadvantaged young people into constructive channels and to turn them away from destructive behavior patterns.

NYSP projects receive an annual on-site review and a written evaluation, and financial reporting is monitored with a program of sample auditing. Technical assistance is provided to all projects through national and regional workshops, and on-site technical assistance is provided to all new projects. Institutions unable to meet NYSP's high standards are replaced.

Since its inception in 1968, the NCAA has administered NYSP on a national basis without charge as a community service. No federal funds are allocated to the NCAA or to individual institutions for overhead. The NCAA donates staff, office space, and supplies, and pays for such NYSP-related expenses as legal fees and telephone, postage, and NCAA NYSP Committee meeting costs. Participating institutions donate educational and sports facilities, equipment, and the services of a project administrator, which last year were valued at more than $10.4 million. Businesses and state and local governments contributed an additional $3.7 million. By combining federal, state, local, and private resources, NYSP was able to provide more than $3 in high-quality benefits and services for each federal dollar appropriated, and to operate at a federal appropriation cost of $112 per participant.

From 1976 to 1987, NYSP received about $6 million in annual federal support. To maintain quality and the number of participants served, the NCAA worked to attract other sources of funding. Despite increased contributions from the NCAA, participating institutions, and area businesses, sharply increasing costs, combined with the declining value of the federal contribution, began to take their toll. Salary ceilings were instituted, the number of projects sponsored, participants, and operating days dropped, transportation was cut back, hot meals at some projects were replaced by cold box meals, and medical follow-up was reduced.

In 1987, the NCAA first sought an increase in NYSP funding above the level at which the appropriation had remained since 1976 and requested an FY 1988 appropriation of $9 million. Ultimately, Congress appropriated $6.319 million that year and $6.669 million in FY 1989. We are putting these increases to good use to restore some of the lost services. This year, the additional funds will be used to achieve cost savings through central purchasing of items such as liability insurance and equipment, and NYSP will provide instructional videotapes on topics such as drug abuse prevention and AIDS.

Much still remains to be done. Salary ceilings, in place since 1985, are greatly impeding the ability of projects to attract qualified instructors, and we urgently need to address this problem. NYSP staff members are classified into four categories: auxiliary staff, professionals, project aides, and support personnel. The auxiliary staff includes the medical coordinator, the enrichment coordinator, the drug specialist, the activity director, and the liaison officer. The NYSP instructional staff includes professionals, such as teachers and coaches who teach sports skills, as well as project aides, who may be college students. Each project must maintain a ratio of at least one instructor to every 15-20 youngsters, and at least one-third of the instructors must be professionals. All NYSP auxiliary and professional staff must have a college degree, with the exception of the medical coordinator, who may be a certified health provider.

NYSP takes pride in the high quality of its staff, many of whom are residents of poverty target areas. Beyond their professional credentials, most staff members are dedicated individuals who truly care about the youngsters. Nonetheless, the salary freeze has made it increasingly difficult to recruit and retain qualified staff. To raise the salary ceilings to any meaningful degree to compensate for the five-year freeze would cost approximately $1.409 million (adjustment of salary ceilings by $500 for auxiliary staff and professionals and $250 for project aides and support personnel).

In addition, operating days, transportation at most projects, and medical follow-up still have not been restored to past levels of service. The cost of restoring these services previously provided would be, respectively, approximately $1.3 million (834 lost operating days x average cost of $1,600/day), $1.31 million (average cost of $10,000/project, minus six projects addressed last year), and $274,000 (average cost of $2,000/project).

Our CSBG appropriation request of $8.743 million will enable NYSP to raise the salary ceilings and to restore transportation at about half of the projects. That figure by no means represents the amount needed fully to restore lost services. In real dollars, the FY 1989 appropriation of $6.669 million is just over half what was provided in 1976 ($6 million x 2.14938 BLS Consumer Price Index inflator = $12.89 million). We have limited our request in recognition of the constraints facing this Subcommittee. We hope that over time Congress can further increase the appropriation to bring NYSP back to its past level of service.

NYSP serves children at risk and is a cost-effective use of federal funds. It also is a wise long-term investment in our nation's youth. This Subcommittee and Congress have shown their faith in the ability of NYSP to teach economically disadvantaged young people the skills and attitudes necessary for personal growth, improved health, and escape from drugs and poverty. Last year, as part of its consideration of the Anti-Drug Abuse Act of 1988, Congress once again demonstrated this faith by authorizing funding for NYSP under the Community Youth Activity Program. This year, NYSP has $3 million in Drug Act funding to enhance the drug abuse prevention component of the program. We are excited by the prospect of using our established nationwide program to educate needy young people about drug abuse prevention.

This year, the amount of drug abuse prevention enrichment instruction will be doubled in the summer portion of the program. The new federal funds are being used to hire and train drug specialists at each project and to operate year-round programming on a pilot basis at fifty of the projects. Our request for $4 million under the Anti-Drug Abuse Act will enable us to continue this work and to operate year-round programming at 15-20 additional projects.

NYSP participants are a key target population for efforts to stem use of illegal drugs, and NYSP has the potential to make a difference with needy youngsters who see drug deals in their housing projects and on their blocks every day. They will not sign up for a drug abuse prevention course in a classroom during the summer months, but they are attracted to a sports program. Once enrolled, our work is to build their self-esteem and to encourage them to resist negative peer pressure and to stay drug-free.

NYSP is a low-cost/high-quality program that works. We therefore request that you recommend an FY 1990 appropriation for NYSP of $8.743 million under the CSBG, and $4 million under the Anti-Drug Abuse Act of 1988.

Thank you very much for the opportunity to testify this morning.

Senator **Harkin**. Dr. Fuller, thank you very much.

Last year it was $6,669,000; the budget request is for zero dollars for this program.

Can you tell me how much money—how many hard dollars the NCAA put into this program last year?

Dr. **Fuller**. I do not have those figures right in front of me, but counsel could get it to you.

Senator **Harkin**. I do not know if you are here representing the NCAA, or if there is anyone else here from the NCAA.

I am going to request those figures from the NCAA as to exactly how many hard dollars the NCAA put into this program last year, and how many dollars they are willing to commit, up front, next year, to this program.

Again, I want to make it clear that I basically support this program. It is a good program, as you say. But quite frankly, I want to know what the NCAA's commitment is to it.

Thank you, Dr. Fuller.

STATEMENTS OF:

ESTHER LAUDERMAN, WAVERLY, WV, NATIONAL BOARD FOR PROFESSIONAL TEACHING STANDARDS

HELEN MARTIN, WEST GROVE, PA

Senator **Harkin**. Next we welcome Esther Lauderman, of Waverly, WV, and Helen Martin, West Grove, PA, representing the National Board for Professional Teaching Standards.

Ms. Lauderman, I understand you were named 1988 Teacher of the Year in West Virginia? Our congratulations.

Chairman Byrd, chairman of the full Appropriations Committee, had wanted to come here, but I was informed that he was tied up this morning, and could not be here.

He wanted me to express to you his regrets that he could not be here to introduce you, and to also extend his congratulations on your selection as Teacher of the Year.

Ms. **Lauderman**. Thank you.

Senator **Harkin**. We welcome you here, and please proceed.

Ms. **Lauderman**. Thank you, Mr. Chairman, for allowing me to testify on behalf of the National Board for Professional Teaching Standards.

We need first-rate teachers if we are to have first-rate schools. Some of those teachers are in our schools today, but their work goes unrecognized and unrewarded. Worse, there are few incentives to encourage them to share their knowledge and expertise with fellow teachers.

We are now hiring over 150,000 new teachers each year. The schools need a fair share of the best that our colleges have to offer. But until college graduates see teaching as a profession which recognizes and rewards excellence, this is simply not going to happen.

The consequence is that not only is State and local investment in schools in jeopardy, but the return on the Federal investment is at risk.

The board was established to set high and rigorous standards for what teachers should know and be able to do. It will offer voluntary professional certification to experienced teachers that will complement mandatory State licensing of beginning teachers.

We will develop not another test, but a mix of assessment processes that reflect the complexity of teaching. It will offer not a single certificate, but more than two dozen.

As West Virginia's Teacher of the Year, I have had the opportunity to speak to teachers, school board members, and State officials about the work of the board. They are excited about board certification.

That is because the board will be a catalyst for enabling legitimate distinctions to be made between teachers, so that schools can be restructured for improved performance.

Teachers today basically have the same job the day they retire as the day they start. It will create incentives for schools to hire the best, not just the cheapest. It will stimulate the design of more rigorous programs of teacher education, and it will enhance teacher self-esteem and consequently improve student learning.

To achieve these results, this will require a research and development program costing approximately $50 million. We are seeking $25 million in Federal funds over the next 3 years, to match corporate and foundation funds.

The funds would be spent on research and development projects selected through an open, competitive process.

I would like to urge the committee to make an initial down payment on this important investment.

STATEMENT OF HELEN MARTIN

Ms. MARTIN. Today, teaching rewards only time on the job and the accumulation of graduate credits, not demonstrated competence and effective practice, and this certainly is not an inspiration for excellence.

I regularly see terrific teachers leaving the classroom for administrative positions or new careers that promise to recognize and reward high-quality performance, and I know how few of my current students ever think of a career in teaching.

The board will change American education, because for the first time, we will have a fair and trustworthy process for identifying our most accomplished teachers.

This will permit the schools to move away from outdated models of school organization that treat all teachers like cogs in an assembly line.

PREPARED STATEMENT

I believe, as do most of my colleagues, that the board will make a significant difference in the quality of education we provide our children. That is why it is so important for Congress to support the board's work. America's children cannot afford to wait any longer.

[The statement follows:]

STATEMENT OF ESTHER S. LAUDERMAN

Mr. Chairman and members of the Subcommittee, we thank you for the opportunity to testify on the need to fund the research and development program of the National Board for Professional Teaching Standards. As teachers, we know first hand of the urgent need to invest in the quality and future of the teaching force.

The nation now finds its schools falling short in meeting the challenges of the modern world. Alarms have gone off in state capitols, in local communities and in many corporate board rooms. The country has come to understand that if we are to have a future with promise we must have world class schools, and that if we are to have world class schools we must have a world class teaching force.

As the nation has mobilized to upgrade its education system, an unprecedented event has taken place. The leadership of the nation's education community has coalesced to establish a National Board for Professional Teaching Standards. Throughout this century teachers have watched as one profession after another established its credibility and increased its stature by creating national certification systems that set high and rigorous standards. Although periodically proposed as a means to elevate the status of teaching and strengthen teacher preparation and practice, the idea languished.

Then, in 1983, the report of the President's National Commission on Excellence in Education sharply heightened public concern, provoking a new wave of reform initiatives that engulfed the education community. Three years later the Carnegie Task Force on Teaching as a Profession in its pivotal report, *A Nation Prepared: Teachers for the 21st Century*, called for the establishment of a National Board for Professional Teaching Standards. One year later, this long dormant idea found that its time had come, and a unique institution in the life of American education was born.

The mission of the National Board for Professional Teaching Standards is to establish high and rigorous standards for what teachers should know and be able to do, to certify teachers who meet those standards, and to advance related education reforms for the purpose of improving student learning in American schools. The Board is designed for experienced, not beginning, teachers whose preparation and experience have enabled them to come to understand how theory translates into practice, to figure out what works, to learn how to judge student behavior and performance and who have matured as professional decision makers. Governed by the profession, and offered on a voluntary basis, National Board Certification will recognize the accomplished practice of experienced teachers and, as such, is seen as a compliment to, not a substitute for, the states continuing system of mandatory licensure for beginning teachers. State licensing systems are designed to protect the public interest; to assure that a teacher will do no harm. Professional certification takes the next step to provide assurance of high quality practice.

Improved Student Learning

The need to achieve rapid and dramatic improvement in American education is now well accepted by those both in and out of education. The National Board offers an opportunity not only to strengthen the teaching profession, but also to restructure schools to capitalize on the knowledge and skills of accomplished teachers. Too many teachers today work in conditions that are not conducive to professional practice or to inspiring talented youngsters to prepare for a career in teaching. Teachers are underpaid, isolated from their co-workers, unable to make critical decisions regarding their practice, and often required to spend valuable instructional time on record keeping and other administrative activities that, at best, are peripheral to learning. Furthermore, teacher education and continuing professional development programs vary widely in quality and relevance to the needs of prospective and current practitioners. Little wonder many students with a range of career options choose not to teach; little wonder that bright and energetic teachers leave the classroom for jobs that are better compensated, that have more vibrant work environments, and that offer real opportunities for advancement and recognition.

There are many fine teachers whose talents go unrecognized and whose knowledge and skills could be a vital resource in assisting new and less accomplished teachers in their efforts to improve their practice and enhance the learning of their students. The National Board, for the first time, provides a trustworthy vehicle for such teachers to be identified on a large scale and for school systems to take advantage, in the best sense, of such talent. While the Board will award certificates, each state and local school district will decide for itself how best to encourage teachers to seek Board-certification and how best to recognize those that meet the standard. The Board will be working closely with state and local authorities in setting its standards, in designing its assessment processes and in identifying ways in which teachers can best prepare for National Board Certification.

Setting Standards and Developing Assessment Processes

Creating an assessment system that can identify the teachers who meet the Board's high and rigorous teaching standards will be a formidable undertaking. In part, this is because the Board's vision of what makes for accomplished teaching extends substantially beyond accumulating course credits and demonstrating command of the basic skills which are the focus of state licensing requirements. The Board is designing a certification system that will recognize teachers who:

- are committed to students and understand how they develop and learn
- know the subjects they teach and how to teach those subjects to students
- can effectively manage and monitor student learning
- think systematically about their practice and learn from experience; and
- can work productively with parents and other professionals.

The start-up of the National Board will require developing and implementing a comprehensive assessment system that fairly and accurately identifies elementary and secondary school teachers who meet the Board's high and rigorous standards. The assessment procedures must be professionally acceptable, publicly credible, legally defensible and administratively feasible. Furthermore, the assessments must go beyond paper and pencil testing. Procedures must be developed to determine not only what teachers know, but also evaluate what they are able to do. Can they translate complex material into language students understand? Can they exercise sound and principled professional judgement in the face of uncertainty, and can they act effectively on such judgments? Assessments that can recognize the complexity of teaching and reflect the diversity and pluralism of American education must be able to accommodate the possibility that there will often be more than one appropriate approach to convey a particular idea, concept or theory to students, and also accommodate the prospect that as the number and mix of students varies so too might a teacher's practice. The assessment methodologies and technologies that the Board needs can not readily be taken off-the-shelf. Consequently, the Board will be breaking new ground. It will explore the feasibility of assessment center exercises, of interactive videos, in-depth interviews, portfolios that are defended orally, simulations and on-site classroom observations along with other state-of-the-art ideas.

The Board is committed to attracting minorities to the profession and seeing current minority teachers stand for Board-certification. It will work to ensure that such teachers are well informed about the Board's expectations and processes, about how best to prepare for certification and about the steps the Board has taken and will continue to take to detect and eliminate examination bias and adverse impact. This will include establishing close working relationships with historically Black colleges and universities and other institutions that enroll large numbers of minority students. A central objective here is to ensure that no teacher declines to seek Board-certification out of a concern that the assessment process is unfair.

The Board's task is substantial, complicated not only by technical issues related to performance assessment, but also by the challenge presented by the size and diversity of the American education system. There are approximately 2.5 million teachers currently employed in the nation's schools and about 150,000 new teachers enter the system each year. The Board must create a valid performance assessment that once in full operation can examine at least 75,000 teachers annually at sites across the country. The assessment must also be designed to accommodate the various fields of instruction that define the nation's teaching force.

The Need for Federal Leadership

In order to achieve its goal of bringing a comprehensive assessment on-line by 1993, the Board must launch a massive research and development effort designed to accomplish in just five years what it has taken other smaller and less diverse professions more than 25 years to do. Unlike many professions that offer a single certificate, the Board will be designing a system from scratch that offers 20 or more certificates; dramatically multiplying the weight of the task at hand. It will take several years and an estimated $50 million to create a state-of-the-art assessment system. Once this initial start-up investment is made and the Board begins operating the certification system, it will become self-sufficient.

While the overall plan is dependent on the Board drawing support from many quarters, timely federal participation is vital if today's students, who are in need of dramatically improved schooling, are to benefit from National Board Certification. The Board is seeking $25 million in federal funds over the next three years. At the same time the Board is undertaking an unprecedented fundraising effort in the corporate and foundation communities to secure non-federal matching funds. This will be followed by fundraising efforts targeted at the states and teachers. Every federal dollar spent on research and development will be matched with non-federal contributions.

The Board will not be conducting its research and development activities in-house. Rather, it will direct such funds to teams of scholars and teachers following a process of public notice, competition and merit review. Not one dollar of federal funds will be targeted to any specific university or other research institution. The Board's research agenda, competitive processes and study designs will be reviewed by both an external Advisory Council made up of leading experts in teaching and related fields and the Secretary of Education, and be open to public comment and scrutiny.

The Benefits of Federal Investment

We believe that this federal investment will return substantial dividends to American classrooms. For example, the Board has the potential to dramatically change the conversation between unions and school boards which for years has been stuck on the premise that all teachers are equally able and committed. Once both parties come to see Board-certification as a trustworthy and fair basis to recognize accomplished teachers, the prospects will improve dramatically for staffing and structuring schools in much more efficient ways than is typical today.

The Board's greatest point of leverage may be its potential to change how schools are organized and managed and to change what teaching as a career is about. Today, our nation's schools contain a good number of Board-certifiable teachers. The only problem is that they are practicing without such recognition. Once they are identified, schools will compete to hire them and they will be offered not just better salaries, but greater autonomy and responsibility. Local districts will look for ways to have Board-certified teachers' influence felt throughout their schools, for to do otherwise would be to waste an extraordinarily valuable resource. America's schools, even operating with current faculty but arranged differently and working with one another in a collaborative manner, will become much more productive workplaces.

The education of "at-risk" children will also improve. In many school districts the standard practice of placing novice teachers in sink-or-swim settings not only costs us many young recruits with substantial promise, but shortchanges students. A reliable means of identifying accomplished teachers will improve the odds that the toughest cases get seen by the best people in the system. This is crucial if the current federal investment in elementary and secondary education is to pay off.

The federal government is currently spending $11 billion annually on elementary and secondary education and this number is likely to grow. The return on this investment is, first and foremost, dependent on the caliber of the teachers on the front lines of education. Federal support for the Board then, in the form of a modest one-time injection of funds, should pay dividends for many years to come.

Support for the research and development activities of the National Board for Professional Teaching Standards represents a singular opportunity for the Congress to exercise leadership to transform teaching into a true profession. In so doing the Congress will not be encouraging just another small change at the margin, but contributing to the creation of a new institution that will serve as a catalyst for the kind of systemic education improvement the country desperately needs.

Conclusion

With these benefits in mind, we urge the Committee to provide an initial downpayment in the 1990 appropriations bill for the National Board for Professional Teaching Standards. We look forward to working with the Committee as you fashion a funding bill that responds to the urgent needs of America's students.

Senator HARKIN. Thank you both for being here.

Now the board, this national board, has already raised private money, has it not?

Ms. MARTIN. Yes; there has been some private fundraising already. The board began with a $5 million grant from the Carnegie Corporation, and then I believe the CEO's of Xerox and DuPont are developing fundraising, and there are significant contributions already in hand.

We are only asking for Federal money which would match privately raised money, and none of the money that we are asking for would be used for administrative purposes. It would all be used for research and development, to develop the high and rigorous standards we are talking about.

Senator HARKIN. I understand that this legislation, obviously, has not been authorized yet? We do not have the authorizing legislation?

Ms. MARTIN. No; I think the Bill 478 is pending before the Labor and Human Resources Committee.

I also just learned this morning that the House will be listening to some hearings on our plans, too, I think June 21. So there is movement.

We just want to make sure that when the—that this committee is aware of the importance of this bill, because it is critical for the future of the Nation.

Senator HARKIN. I understand the board has already accomplished a great deal. They have gotten most, if not all, of the players, I guess, for lack of a better word, in the education community together behind it?

Ms. **Lauderman**. This is the only organization like this that exists in the country, and the only endeavor of this magnitude.

Ms. **Martin**. We have the leaders of the two major teacher unions. I am a nonunion teacher. We have corporate chief executive officers, we have two Governors, we have classroom teachers, we are both classroom teachers and leave lesson plans while we are here with you, and so it is a cross-section of the people who are affected by education in the Nation.

Senator **Harkin**. I am a cosponsor of the Dodd bill to——

Ms. **Lauderman**. We are very appreciative of that.

Ms. **Martin**. Yes.

Senator **Harkin**. I do not know—we will see how we can move it this year.

Senator Dodd has said something about trying to get it through in June, maybe July.

That would be in time for us to do something on the appropriating end.

Obviously, we run into a lot of problems trying to appropriate without an authorization, but I think it is a worthwhile endeavor.

I am very encouraged by what the board has already accomplished, and I think that it is something that is needed. We will see what we can do.

Ms. **Lauderman**. We appreciate it very much.

Ms. **Martin**. Yes; we certainly do.

Senator **Hatfield**. Mr. Chairman, I am very deeply immersed in this whole area of educational certification and standards from a number of perspectives.

I am working with a number of groups now, particularly as it involves science and mathematics.

Over the years, I have given very strong support to regional education laboratories, and I must ask—I think I need clarification.

It seems to me that we have got dozens of research programs going on, and I have a feeling that there is no coordination amongst them, and that we are spending millions of dollars for a problem that we all recognize, and that is the quality of our education, the plummeting of the quality of our education, as demonstrated by the poor scoring of our students in competition and in contrast to students from other countries of the world, particularly in math and science.

I could go on and on. In our secondary schools, only 50 percent of our science and math teachers are certified, because really, the others are not qualified to teach it, and they are putting warm bodies in the classroom.

The fact, Mr. Chairman, that out of our 25,000 high schools, we have dropped physics in 9,000 of them, chemistry in 7,000, and biology in 5,000 of them, because we just cannot find the teachers—on and on and on the statistics go.

But the basic question I am getting to—your board and whom you represent wants to undertake this massive research project, with a lot of money involved.

These various and sundry specific boards of certifying for science or certifying for math, school boards association, my State of

Oregon, these educational labs, are all undertaking a research project of some kind.

My No. 1 question—do we not have some dusty old research projects that we have already made that we have never done anything with?

I can tell you, in Washington, DC we have the Kerner Commission study, we have the Grace study, we have all the studies in the world, and those studies are not worth a tinker's continental unless they are implemented.

I want to know what the implementation is going to be, once the study is done, and I want to know, second, how this study will be coordinated with all the other studies that are going on, at millions of more dollars.

Now, I am sympathetic—I am a friend. I am not asking these questions in an adversarial way. I am just merely saying that I am disturbed that, No. 1, we have made studies all our lives. All my political life, I have helped fund, at the State level while I was with the State legislature, when I was the Governor, and in the Federal Congress, and I have always asked the question, what happened to them once we did them? And nobody can ever give me that answer.

And, second, how are we coordinating these with all the State activities and all the other board activities?

Ms. **Lauderman**. Senator, I would like to start by saying that currently there is no off-the-shelf assessment sitting there ready for teachers that will assess what teachers should know and be able to do. There is just nothing out there.

And as these board members come together, what we are doing, and it is very difficult, is determining what should teachers know and be able to do? And with the constituency that you see represented——

Senator **Hatfield**. Are you telling me that this is the only group that is addressing that issue?

Ms. **Lauderman**. Yes, sir; yes, I am.

It is the only—nowhere does there now exist an assessment or the knowledge to know what it is we are going to assess and how we are going to assess teachers in a way that truly—that they can demonstrate their knowledge in a performance based assessment.

Ms. **Martin**. I can speak directly to the National Science Teachers' Association, because I am a member, and I am a science and math teacher, so I am critically concerned about this whole issue.

I am acutely aware of how they are developing some certification standards, and they are leaders in the field, and all this. At this point in time, they certify science teachers based upon the number of courses you have taken and the grades you have received.

I am convinced as a science teacher that the people who sit in classes and get grades—there is not a direct relationship between that and the ability to understand what science truly is and to enable students to understand the process of science and enjoy science and want to go on to be the scientists and mathematicians that we need in our Nation.

It is more than just knowing science and getting a grade in a course. It is the ability to communicate it, to understand the needs of the students, to deal with the individual students, with the individual situations.

There is pedagogical knowledge directly related to science. There is knowledge related to general pedagogy, and there is also science-specific knowledge, and there is no board, no force, now putting all of that together.

We are talking about a force that is at work in not just science, but mathematics and English and pre-K, and——

Ms. LAUDERMAN. We are looking at at least two dozen different certificates.

Senator HATFIELD. Once you get this study done, and this board announces it, what guarantee do you have that all of these little components underneath it all have their little turfs, and are going to accept it?

Ms. LAUDERMAN. Well, Senator, we by no means mean to usurp the authority of the States. The States will still have their licensing process as they always have.

Senator HATFIELD. So they can ignore it, put it in the file drawer?

Ms. LAUDERMAN. In my own State of West Virginia, they are looking—all of our authority are looking very closely at the work of the national board, and have even allocated—I believe we are the first State to allocate money to work with the national board in looking at our own licensure procedure, so that we can gear up and get ready for the national board when it occurs.

Senator HATFIELD. But you have no commitments that anybody is going to do anything about a report of this kind, once it is done?

Ms. LAUDERMAN. The one thing that I can say is that the former president of the National Science Teachers Association, the former president of the National Council of Teachers of Mathematics, as well as other disciplinary societies—these people serve on the board.

The work is not fragmented now, as it might appear to be in some of the literature. It really is a joint effort.

I know directly from Mary Beth Rowe, the president of the National Science Teachers Association, that they undertook the problem of science teacher certification in order to help the board prepare for national certification.

Senator HATFIELD. Do you have any communication or any database at all that indicates that there is a constituency out there that wants this?

Ms. LAUDERMAN. Yes.

Senator HATFIELD. And would be willing to accept the results, and try to implement the results?

I would like that for the record.

Ms. LAUDERMAN. We will certainly get that to you, Senator.

Senator HATFIELD. Because I—over the years, I have not found very many unified efforts amongst educators——

Ms. LAUDERMAN. This is what makes this——

Senator HATFIELD. Or amongst educational disciplines.

Ms. LAUDERMAN. This is what makes this so different. We have all of those disciplines represented on this board——

Ms. MARTIN. And the school boards.

Ms. LAUDERMAN. The school boards association. We have the two teacher unions represented, the heads of the unions, as well.

Ms. **Martin**. Two State school officers are involved, and the president of the national PTA.

It is a very exciting effort, and I can just tell you one thing that I would like to share with you, that I all my life wanted to be a teacher.

I think it was the biggest disappointment when you spoke at my college graduation, Senator, and I was so proud to graduate from the King's College, back in 1967, and I went home to my home State, and teaching was not elevated.

Senator **Hatfield**. Oh.

Ms. **Martin**. And that was important to me.

Senator **Hatfield**. Of course.

Ms. **Lauderman**. As you can see, we feel that teachers, teachers like ourselves, do have a very vested interest in this, and that is why we are here today, and not other people from the board.

Senator **Hatfield**. Yes.

Well, I merely am trying to be helpful, except that I do want to make sure that this has a constituency, this has some kind of a hope that once it is completed, it will be accepted.

I need not tell you the proliferation of educational governing agencies, governing boards, the proliferation of educational societies and professional groups. You are more proliferated, probably, than any other single profession in this country.

And as a result, to try to get some kind of a standardized approach to anything is very difficult.

I would also like a commitment. I hope that when you develop those standards and those assessments of those standards of what they should be, that you will provide one clause for an exception, and that is the exception being that a person with on-hands skills, without the so-called college degrees, has some opportunity to make a contribution.

Ms. **Lauderman**. I think that we all realize that there have to be alternative routes into the profession, because we realize that there are many people who have had experiences which are directly related to education—even in industry, I can think of a DuPont physical chemist I know that is an outstanding teacher, and yet he does not have the education courses.

If we set these high and rigorous standards for which teachers can aspire, then these people also can join the profession and try to meet these high and rigorous standards.

Senator **Hatfield**. I hate to have these situations. I am out there in industry trying to get industry to take on more responsibility for the local education programs, particularly in science and math, and industry says:

> Well, we would be very happy to give one of our scientists at high wages, high salary, to teach a course, but he has not had the local, the State history, therefore, he cannot enter that classroom because he does not have the union card of that particular requirement or the union card of that State.

Ms. **Martin**. I think there is also the concern there, among those of us who really care about the profession—and I work with a number of people in my classroom on a regular basis. I have a retired gentleman who comes in almost weekly to work with my students on weather satellite technology—and there is a concern, for those of us who are classroom teachers.

We realize that some of these people do not really have the skills required to be in the classroom with young people. They do not understand certain aspects of learning or pedagogy. They may know the content very well.

It is critical that as we make, as we open our arms to encourage new people to enter the profession, especially in the areas of science and math, where we have the deficiencies, that we also realize, simultaneously, that we are not just pulling anyone in from industry, but that these people must—you know, we would want them to meet the high and rigorous standards.

Obviously, many will. But we need to make sure that those standards are high and rigorous, and not history 101 from a local State.

Senator HATFIELD. I could not agree with you more.

The university where I taught for 7 years, we had one of the outstanding artists in our State, who had never been to college, and we were able, because of the flexibility of a private university, to be able to say, "All right. We will call you an artist-in-residence, rather than professor."

Ms. MARTIN. We would want to make sure they knew the knowledge, yes.

Senator HATFIELD. We got the talent and the skill of that person integrated into a university faculty without any of the educational degrees that most of the other faculty had.

I just would like to see a little flexibility at the secondary level, too.

Ms. MARTIN. I think that we are looking at the body of knowledge and realizing that that must happen.

Thank you very, very much.

Senator HATFIELD. Thank you.

STATEMENT OF SAM HARVEY, VICE PRESIDENT FOR URBAN AFFAIRS, GEORGETOWN UNIVERSITY

Senator BURDICK [presiding]. Good morning, Mr. Chairman.

Mary Albert, Georgetown University.

Mr. HARVEY. Yes; I am Sam Harvey, vice president for urban affairs from Georgetown.

I bring you Mary Albert's regrets. She was unable to be here. I have just a couple of items that I would like to make a comment on.

Health education assistance loan, the Hill program—we believe the program runs well, quite effectively, as it is now set up, and we would urge the committee to allow the loan guarantee limit to go to $330 million, rather than lower it to the $100 million as requested by the administration.

Nursing education support—we urge the committee not to accept any budget recommendations that zero out support for the health professions, especially graduate nursing training, which we believe is badly needed.

The integrated academic information management systems [IAIMS], which is part of the National Library of Medicine, needs additional support, and we would recommend an increase from $3 to $6 million in support.

Included in the submitted testimony is a letter which speaks to Georgetown University's participation in this particular project.

There are three title VII programs in which we are involved, and just to come in about those—those three programs are evaluation assistance center, the bilingual education service center, and the educational personnel training and fellowship programs.

Each of these programs is in its own right providing much-needed and important services to needy and deserving persons. We encourage the committee to continue to offer support for these efforts under the existing legislation.

Cost-effective services are reaching those persons at whom the legislation was directed.

PREPARED STATEMENT

Finally, regarding college housing and academic facilities loan programs—we would urge the committee to support a level loan authority of $60 million. This program provides a much-needed service to higher education across America.

The need for money for academic facilities and renovation of those facilities cannot be overemphasized.

That completes my testimony.

Senator BURDICK. That is fine. Thank you.

[The statement follows:]

STATEMENT OF MARY S. ALBERT

I am Mary S. Albert, Director of Government Affairs of the Georgetown University Medical Center. There are several issues of importance to the Medical Center which we would like to present to you. I regret that Fathers T. Byron Collins, S.J. and William L. George, S.J. cannot be here today.

Health Education Assistance Loan (HEAL) Program. In this program health professions students can borrow the funds they need to complete their medical education from private lenders, with the loan guaranteed by the Federal Government. The loan is not subsidized, and presently students pay an up front 8% premium into an insurance fund to cover defaults.

Each year successive administrations have sought to limit the loan volume of HEAL to $100,000,000. This is not a practicable limit since, for example, in FY 1988, $229,000,000 of loans were guaranteed. We urge that that loan guarantees be allowed up to $330,000,000 million, less than the recently reauthorized.

The Administration's budget also seeks authority to raise the initial insurance premium to cover possible increased defaults; they also request that lenders be liable for 20% of defaults, and that schools be responsible for 5-10% of the loans depending on the default rates of their students. HHS has consistently overestimated HEAL defaults. Until there is more reliable forcasting from the new legislative and regulatory requirements, such substantive changes should not be considered. Moreover, such changes do not belong in the appropriations bill.

Nursing Professions Support. For several years, successive administration budgets have attempted to cut out health professions support. Once again, nursing education support has been entirely eliminated in the budget. Once again, we urge the Congress to restore the present level of support. As you know, the shortage of nurses is a nationwide problem, and it is important that graduate nursing support be continued, as graduate nurses provide the leadership cadre which can best help the profession adapt to its changing roles which include more ambulatory care, more intensive and technological care, and an enhanced role in the primary care team. Please restore this important educational support.

Integrated Academic Information Management Systems (IAIMS). Our Medical Center has been one of the early participants in the program and has been able to effect dramatic changes in the way information is coordinated and transmitted within the Medical Center. As the increasing amount of medical information being generated floods into the health care delivery system, new ways of integrating information systems provide tools not only to our students and * * *.

[Letter from Dr. Edmund D. Pellegrino, Georgetown, University]

Dr. Donald A. B. Lindberg
Director, National Library of Medicine
National Institutes of Health
8600 Rockville Pike
Bethesda, MD 20209

May 2, 1989

Dear Don:

I appreciated the chance to talk with you about the support of our Bioethics Information Center. I am glad that you agree that a contract arrangement is best for the long term future. As you know, we have operated the center for four years with NLM support.

We are agreed that we will continue, however, on the current basis for fiscal 90. In accordance with your advice, we plan to reapply for continuation of the present grant. In fiscal 91, we will work with you on a contract for support in the neighborhood of $450,000 to $500,000 per year.

Like you, we are much impressed with the present work and future potential of the IAIMS project in which Georgetown University is a participant. We are prepared to support your request for budgetary support for this extremely important program.

Sincerely,

Edmund D. Pellegrino, M.D.

cc: Father Byron Collins, S.J.
Dr. LeRoy Walters

STATEMENT FROM GEORGETOWN UNIVERSITY

Mr. Chairman and members of the Committee, we are Samuel Harvey, Vice President for Urban Affairs of Georgetown University, and Rev. T. Byron Collins, S.J. and Rev. William L. George, S.J., Assistants to the President of Georgetown University for Federal Relations. Thank you for this opportunity to testify.

The Georgetown University Evaluation Assistance Center provides technical assistance on the evaluation of educational programs for limited English proficient students in the eastern half of the United States. The Georgetown Evaluation Assistance Center is one of two such centers funded nationally by the Office of Bilingual Education and Minority Languages Affairs in the U.S. Department of Education under ESEA Title VII. Serving thirty one states, the District of Columbia, Puerto Rico, and the Virgin Islands, the Georgetown Center continues to achieve the goals of Title VII, section 7034, by assisting States and Localities with the methods and techniques needed to identify the educational needs and competencies of those with limited English proficiency, and by assessing the educational progress attained through such programs.

Through workshops, on-site and telephone consultation, regional meetings, written communication, materials development on timely topics, and a toll-free hotline, the Georgetown Evaluation Assistance Center has proved its worth. The Congressional restriction of these centers to institutions of higher education has also proven its wisdom. Institutions of higher education can fill the role effectively, providing cost-effective service, an appropriate mix of staff expertise, and concern for the quality of products and services, not a vested profit interest.

Together with its counterpart at the University of New Mexico, the Georgetown center has effectively served the entire nation. Additional centers would only increase costs without providing additional benefits.

Finally, the ability of the Georgetown Evaluation Assistance Center to provide more appropriate service to the clients in our region, would be greatly improved by a contract modification expanding the number of personnel from the current level of 5.0 full time equivalents (FTE's) to a higher, 7.0 level. The relevant Request for Proposal permits such contract modifications.

Georgetown University is also proud of its Bilingual Education Service Center, one of the 16 Multifunctional Resource Centers funded by the Office of Bilingual Education and Minority Languages Affairs of the U.S. Department of Education, under Title VII. Through this program, Georgetown

University has served eight states (DE, KY, MD, NJ, OH, PA, VA, and WV) and the District of Columbia since October 1980. This long-standing association between the Center and the educational personnel

* * *.

Mr. Chairman and Members of the Committee, we are Rev. William L. George, S.J. and Rev. T. Byron Collins, S.J., Assistants to the President of Georgetown University. Thank you for the opportunity to testify on the College Housing and Academic Facilities Loan Program.

We would like to ask the committee to support a level of loan authority of $60 million. The College Housing and Academic Facilities Loan Program provides a much needed service to higher education across America.

The need for money for academic facilities renovation cannot be overemphasized. Educational institutions have been forced to assume a greater responsibility for student aid, as Federal assistance for this has declined in recent years. This financial burden together with the demands of inflation, energy costs, and staff salaries have resulted in a serious problem of deferred maintenance. In addition, modernization of existing buildings to conform to new safety standards and to accommodate computers and other technologies are also raising the renovation costs on campuses across the United States. The cost of catching up and keeping up in regards to maintenance is more than most institutions can afford. It has recently been estimated that colleges and universities need to spend at least $20 billion for immediate repairs if they hope to save their crumbling and outdated buildings. These funds are required for facilities replacement, renovation, and improvement. Adding to this already crippling problem, another 40-50 billion is estimated for less urgent repair work to prevent further deterioration. Currently most colleges spend less than half of the amount actually needed to properly maintain their academic facilities. Based on 1988 priority needs and funding levels, U.S. colleges and universities will defer $4 of needed maintenance for every $1 spent (Higher Education Facilities Survey by the National Association of College and University Business Officers and the Association of Physical Plant Administrators, January 1989).

Federal participation in financing academic facility renovation is needed. It is often difficult or impossible for schools to find loans for academic facilities that depend on tuition charges. In many cases, this program is the only way that schools can obtain critically needed funding. However this year, the Department proposes to repeal the statutory requirement that the Secretary not sell college Housing Loans after September 30, 1988. The effect of which will add to the burden of searching for funding by the universities and colleges. The short term goal of the Department is a reduction of the outstanding balance and interest payments to the Treasury,

* * *.

STATEMENT OF MARK DeLONG, PRECOLLEGE TALENT IDENTIFICATION PROGRAM, DUKE UNIVERSITY

Senator **Burdick**. The next witness will be Mark DeLong, of Duke University.

Mr. **DeLong**. The Talent Identification Program, where I am the director of operations—I have already submitted a written statement, and I would like to address certain points in that.

The main point that I want to highlight is that Federal funding implies in gifted education exactly what it implies in other areas. It specifies a national concern, and that, I believe, is the single critical role that the Federal Government can play to enhance gifted education.

Perhaps I complain a bit too strongly about chapter II block grants in my written statement, but I do know that these funds have been well used in the States to further the education of the gifted. Those funds should be continued, but through more direct funding, the Federal Government should recognize and indeed proclaim the gifted and talented youth of our Nation as an extraordinary national resource.

Because the gifted and talented are a national resource, their nurturance should be informed by a national vision. Funding could initially help to define that national vision through, for example, a national planning group for math and science education, working under the aegis of the national center.

Federal funds for the gifted and talented could work through regional centers, to link special educational materials with those who would use them, and to work on the tricky questions of talent identification.

TIP, where I work, has placed a high priority on serving talented disadvantaged and minority students. One of the intensive efforts that we undertake every year is the talent search, which encourages high scoring seventh graders to take the SAT or the ACT assessment.

The response to our talent search, and the research conducted on it, indicate that the results of these tests are useful to children, to their parents, and to their schools, but we do not delude ourselves to think that TIP's talent search is the sole means of identifying gifted youth.

We recognize that our talent search naturally appeals to those families with solid educational backgrounds. Indeed, the talent search is economically feasible because of that appeal.

We have embarked upon pilot projects to find the talented children who do not respond to the framework we have developed in the talent search. Identification of the talented minority and underprivileged youth is more costly, more difficult, because it needs to take on a different face from that of our talent search.

To identify talented children at risk means working earlier than the seventh grade, as we do. It means working closely with schools, parents, and community organizations. It means tying the indications of potential gifts with educational programs that actualize and develop them.

It means spending money to help gifted kids capitalize on their strengths. TIP has worked to bring underprivileged youth, and minority children, to a point where they can make the claim that the inner strengths of their own giftedness offers.

PREPARED STATEMENT

But TIP and other organizations like it do not have the resources to do the job that needs to be done for the underprivileged populations of the United States. The Federal Government has resources and it can help those underprivileged youth by using the instrument of funding to help establish educational priorities.

Thank you.

Senator Burdick. Thank you.

[The statement follows:]

STATEMENT OF MARK R. DELONG

I speak from my experience as a teacher of academically talented youth, as a staff member of the Duke University Talent Identification Program, and as a co-worker with concerned teachers and parents who daily face the challenge to respond to the special needs of the gifted and talented.

Currently, federal funding for the education of the gifted and talented in the main comes from Chapter 2 Block Grants by virtue of its inclusion in one of the six categories of use. The category includes "other innovative projects which would enhance the educational programs and climate of the school, including programs for gifted and talented students, technology education programs, early childhood education programs, community education, and programs for youth suicide prevention." Under these revised categories of use, projects for the gifted and talented compete with some very popular programs, and it remains to be seen whether that fact dilutes local or state commitment to allocate Chapter 2 funds to the education of the gifted and talented. We believe that in the past Block Grant funds have been an unreliable source of federal support for gifted and talented education.

The Jacob K. Javits Gifted and Talented Children and Youth Education Act of 1988 allows for a funding beyond the Chapter 2 Block Grant funds. I might say that the passage of the Javits Act has generated considerable excitement in our small world of gifted education; and, as a result, the law has gained considerable symbolic meaning. Under the Javits Act, $7.9 million for the current fiscal year has been appropriated for disbursement by the Department of Education for the education of gifted and talented children and youth. Of that amount, $6.2 million will be awarded in discretionary grants and $1.5 million will be spent on a National Center for Research and Development in the Education of Gifted and Talented Children and Youth. The Bush administration has proposed to maintain funding at the $7.9 million level for fiscal year 1990.

All of us in gifted and talented education circles welcome this fiscal year's investment, though when we look at the bottom line, we also see the disparity between the tasks of our mission and the resources necessary for those tasks. Eight million dollars is more money than we've seen in a long time, but less money than we need. One of the people I talked with–a person who testified on behalf of the Javits Bill–told me that in order for the United States to have a good response to the needs of the academically talented, the federal government would need to spend $50 million a year.

I called around after I learned that I would be testifying before this subcommittee. I wanted to find out what others in the field believe are the pressing issues of meeting the challenge of educating the gifted and talented. There was no dearth of ideas.

Minus pet projects and rhetorical embellishments, my informal poll revealed that science and mathematics education is on everybody's mind, training programs for teachers (in-service and pre-service) need considerable improvement in order to help them serve gifted students in their home schools, and there is considerable concern about the identification of talented children from underrepresented minority groups and with economically disadvantaged backgrounds. It is a happy circumstance that the Javits Act emphasizes exactly these points.

My experience at the Duke University Talent Identification Program has shown me that when we sin in our profession it is when we underestimate what needs to be done and what we can do. Simple illustrations:

- In 1981, our first annual talent search, which invites talented seventh graders to sit for the SAT or the ACT, we had about 11,000 applicants. That figure was well above the 6,000 we had assumed was possible. Since then, the talent search has grown to over 50,000 seventh graders, eight times our original expectations.
- In 1986, we expected that a fledgling project to provide teachers with models for Advanced Placement courses would distribute about 300 "AP manuals" to teachers. Today, a copy of those materials is in use in every state in the Union, and we estimate that about 75,000 students benefitted this past school year from the project. We have distributed about 7,000 manuals.
- In 1981, TIP ran a modest summer program for highly gifted youth, and 151 students attended. For this summer's program, the residential and teaching staff will number over 150. The tragedy is that we have fewer class spaces than we have qualified applicants.

Those points indicate that the need is great for services from TIP. But they also show that America has a great store of human talent, much of it unidentified because it is unimagined.

Appropriations to continue what was begun this fiscal year under the Javits Act are especially important for two reasons: First, the Javits Act can serve greatly by signalling a national concern for a national resource. The National Center serves to focus–it will have symbolic power. Just as effectively, the projects initiated by discretionary grants and through the National Center will need to continue and grow in order to develop and preserve the youthful talent of our nation. If we falter in that support, if we fall back into the dogmatic slumbers of the past decade, we will later learn that we will have wasted greater resources than we have "saved."

Federal involvement in developing human talent has never been more critical than it is today. It is hardly worth mentioning the impeding shortages of American scientists and engineers. Although that threat to our economic and technological competitiveness forms a starting point to our concern for the gifted and the talented, my concern and that of my organization has been what reception the talented and gifted receive today in their schools. That response, I believe, has been hampered by well-intentioned efforts to increase general knowledge through our schools. But what has worked for the average student does not necessarily work for the gifted. Indeed, these children often outperform even their teachers.

At the Talent Identification Program, for example, exceptionally talented youngsters apply to our Summer Residential Program with academic achievements almost beyond belief:

- A sixth grader from Raleigh, North Carolina, applies for advanced work in physics. Even before his middle school years, he has completed the pre-calculus sequence and is enrolled in a calculus course at North Carolina State University.
- An eleven year-old attends the Summer Residential Program to study number theory, a topic that mathematicians usually tackle in their undergraduate or graduate studies.

Such achievements are truly exceptional. And because they are exceptional, they also push the limits of the public educational system. No doubt, the sixth-grader in Raleigh has successfully worked with the public educational system.

But this sixth grader's case is hardly typical. The same week that his application arrived in our office, Ivana Markovic, a sixteen year-old from Lilburn, Georgia, accepted a place at the Massachusetts Institute of Technology (turning down Vanderbilt, Duke, Emory, and Georgia Tech). Although she speaks three languages and has completed more math than the average high school graduate, she was unable to receive a diploma for her high school work because of Georgia's commitment to administrative policies. As the Associated Press rather dramatically reported, her "record is good enough for her to be accepted by five top universities but not good enough for the Georgia Board of Education to give her a diploma." Again that same week, I received a call from a parent whose ninth-grade son Peter was currently excelling in an Advanced Placement Calculus course. Her problem was the administrative restraint of her son's school. Peter would need to "get credit" for Algebra II or else he would not qualify for his diploma, in effect requiring him to retake a course which was in fact a prerequisite for the very course he was currently taking. When I later talked with the boy's school counselor, I was informed that the problem, in part, was that the boy was "too smart." His achievements could not fit into the way that the school kept student records, and he was learning beyond the abilities of his teachers to teach. His case was an administrative hassle, something beyond the ken of educational administration.

My colleagues at other universities have their own stories of other Ivanas and other Peters. They have confronted situations where indefensible educational decisions were made for the sake of educational administration cloaked in the garb of "educational reform" or "quality." As it relates to gifted and talented children, we risk transforming conformity into "reform," all the while believing that in tightening standards for credit we have transformed educational quality into measurable, neatly parcelled, normative administrative units. Children like Ivana and Peter face such a system. They deviate from norms while also pushing at the highest qualities of educational quality.

Funding for the gifted and talented through the Javits Act in itself is meaningful because it is a signal of federal involvement. The state policies which restrict the Ivanas and the Peters of the nation have had no true national context, because those policies have had no vehicle for federal leadership. This next round of appropriations will send a new message to those of us in gifted education circles and to those of us who try to help schools respond to the special challenges and promises of gifted children and youth. We have begun to define a federal role in education policy for the gifted. We have in the present fiscal year to state what the extent of our commitment is to harvest a national resource of talent.

This year's appropriation of $7.9 million needs to be increased to give the National Center created by the Javits Act more than symbolic power. That appropriation needs to be increased to expand the influence of discretionary grants so that projects of identification and education are felt by the underprivileged and the disadvantaged. Our nation needs to invest $20 million in 1990 to set forth on a greater harvest of talent, for the greater richness of our people, our economy, and our culture.

The collaborative efforts focused by a National Center and engendered by discretionary grants in this and the next few years can be instruments to do what Thomas Jefferson saw in his vision of American public education. The gentleman from Monticello, probably overlooking his tilled rows or his compost heap, wrote that in American education "geniuses will be raked from the rubbish." Thanks to the successes of American education and the genius of our people, our national treasure of youth is by no means "rubbish." But "geniuses" remain hidden and those that we see are underdeveloped and underused. Government appropriations will help to to reveal that greater treasure and make our nation as rich in achievement and leadership as it is in potential and human energy.

STATEMENT OF DAVID MAX McCONKEY, NATIONAL DISSEMINATION STUDY GROUP

ACCOMPANIED BY:

MARY ALICE FELLEISEN
RAY HARTCHON
SUSAN WILLIAMS
JUDY McKNIGHT

Senator BURDICK. Next witness will be Max McConkey. Welcome to the committee.

Mr. **McConkey**. Mr. Chairman, I would like to introduce a few of my colleagues who are here with me this morning.

Senator **Burdick**. Supporting cast?

Mr. **McConkey**. I beg your pardon?

Senator **Burdick**. Your supporting cast?

Mr. **McConkey**. Yes; the supporting cast.

Mary Alice Felleisen is a developer-demonstrator in the national diffusion network from Pennsylvania. She is here on my right.

To her right is Ray Hartchon, who is a State facilitator in the national diffusion network, from Maryland.

To my left is Susan Williams, a State facilitator in the national diffusion network here in the District of Columbia, and to her left, Judy McKnight, who serves that same function in the State of Virginia.

Mr. Chairman, we appreciate this opportunity to appear before the subcommittee. Thank you for inviting us.

My name is Max McConkey, the executive director of the National Dissemination Study Group, and my colleagues and I in that association, which represent the men and women who represent the projects in the national diffusion network nationwide are here to request that the subcommittee increase the appropriations for the national diffusion network in this fiscal year to $13 million.

Granting this request would mean a return to a commitment made by the subcommittee when it provided $14 million to the national diffusion network just 10 years ago, in 1979. This was later reduced, in the eighties.

This year, 1989, represents the 15th anniversary of the national diffusion network, and it is a program of research in action. It is a program of dissemination of exemplary programs, of curricular programs across the country that work to the schools, to the teachers, to the students that need them.

Essentially, the NDN is a transfer of programs that have proven successful in one classroom to another classroom elsewhere in the country that needs those services. It is a program that works.

It is an enormously cost-effective and successful program, each year benefiting on an average 2.5 million students, the training of 50,000 to 75,000 teachers.

Yet, this program, which has been so enormously effective and has demonstrated its effectiveness over 15 years, is tragically underfunded, such that some grantees in the national diffusion network have not even reapplied for funding, because the basic grants are so small.

We, in the professional associations, share strategies with each other, just in an attempt to keep our projects alive.

Finally, there are not enough substantive programs in the national diffusion network now, as we enter the nineties, to meet the emerging needs of America's schools. We would like to respond to new national needs, whether they be in bilingual education, in literacy, in drug education, in math and science, and to some extent, we are attempting to do that each day, each month, each year.

But there are not enough new programs entering the system, and, frankly, there is not enough substantive support from the administration financially to provide that kind of assistance.

PREPARED STATEMENT

So we ask the subcommittee if it will examine, given the many priorities that you have, the possibilities of increasing modestly the appropriations for the national diffusion network this year to a total of $13 million.

Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF DAVID MAX MCCONKEY

I am Max McConkey, Executive Director of the National Dissemination Study Group, a non-profit association of educators from throughout the country. The Study Group's purpose is to promote school improvement through the dissemination of educational practices that have proven to be successful. Accompanying me from the National Dissemination Study Group is board member Mary Alice Felleisen, from Pennsylvania, who directs a National Diffusion Network Developer Demonstrator project based in that state, "Project First Level Mathematics," and directors of several of the NDN's State Facilitator projects from this area.

We are pleased to have received your invitation to appear before this subcommittee in support for increased appropriations in fiscal year 1990 for the National Diffusion Network (NDN). The NDN, reauthorized by Congress last year, was granted initially an $11.2-million appropriations for fiscal year 1989 (its authorized funding *floor*), but the deficit reduction measures late last year cut the NDN's current appropriation to $11,066,000.

Our professional association, the National Dissemination Study Group, which represents the men and women who operate the National Diffusion Network grants, as well as educators in the schools that these programs serve throughout the country, urges this subcommittee to increase the funding of the NDN to $13-million in fiscal year 1990.

Such an increase would represent the start of a return to the original commitment made by this subcommittee nearly 15 years ago to extend to our nation's schools the opportunity to make use of the best school improvement practices. In fact, just ten years ago, in fiscal year 1979, the Congress made $14-million available for the National Diffusion Network. With cutbacks in 1980, the NDN's support was reduced to 10-million, and its support has averaged just slightly more than $10M each year since: in effect, NDN funds have been frozen at $10 to $11-million/year for nearly a decade. Had the National Diffusion Network's appropriations of the mid-1970s kept pace only with United States inflation, the program would today be ***level-funded at over $40-million.***

Despite the severe financial handicaps it has suffered over the past decade, the NDN has survived, largely because of the dedication of its people: the thousands of devoted project directors and staff and school teachers and administrators, who have maintained their commitment to keep alive this torch -- this national network of successful school programs, which studies have indicated may be the most successful, basic school improvement effort ever funded by the federal government.*

The National Diffusion Network is a program created in 1974 and administered first through the Department of Health, Education, and Welfare's Office of Education, later through the Department of Education's Office of Educational Research and Improvement. The NDN is designed to carry out the Congressional mandate to improve educational quality through the dissemination of exemplary programs to school districts throughout the Nation -- thus promoting and encouraging excellence in education. It operates through two basic components -- State Facilitators and Developer Demonstrators. State Facilitators, located in every state, provide information about education programs to public school districts (as well as to private and parochial schools) seeking to improve their educational practices. Developer Demonstrators are projects throughout the country that represent locally-developed, thoroughly implemented and evaluated, exemplary school improvement practices. Each program has been selected by a special federal board; this group, called the Program Effectiveness Panel provides a thorough, non-political, expert, and objective assessment of each project and certifies the effectiveness of successful applicants.

These exemplary school improvement practices -- nearly 500 in all have been validated as exemplary since the NDN began -- are made available for dissemination through this national system. While limited resources have meant, unfortunately, that the Education Department is only able to fund, on average, a total of about 75 Developer Demonstrator awards each year, all active, validated programs are described in a catalogue -- *"Educational Programs That Work"* -- sponsored by our professional association. The catalogue lists projects in writing, mathematics, reading, early childhood education, humanities, science, special education, bilingual and migrant education, and approximately 60 other categories.

The NDN process works like this: an elementary school in Iowa identifies a need for a new direction with instruction in mathematics on the kindergarten and first grade level; the school principal contacts the

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* e.g., Stanford Research Institute (1977); *"People, Policies, and Practices: Examining the Chain of School Improvement, Vol. VIII,"* DESSI, The NETWORK, Inc. (1982)

NDN's State Facilitator in Iowa -- Michele Soria-Dunn, whose office is located at the Department of Education in Des Moines -- and reviews with her that particular need. After carefully reviewing a variety of program options available, the State Facilitator, who later meets with the school's leadership and instructional personnel, recommends the well-regarded project "Kindermath," directed by Mary Alice Felleisen and located in Devon, Pennsylvania. After a thorough review of Kindermath materials and other information, the Iowa school decides to "adopt" the Pennsylvania math project. Within a month's time, Mary Alice travels to West Virginia -- with those expenses shared by the school, the Iowa State Facilitator, and Mary Alice's NDN Developer Demonstrator project grant -- and, over a three-day period, trains the school's kindergarten and first grade teachers. The teachers begin implementing the curriculum immediately, and Mary Alice returns for a follow-up visit during the next academic year. Assessment scores show that the math gains of the children in the Iowa school soar, as they have in the original Pennsylvania site and in each of the program's other "adoption" sites throughout the country.

The initial cost of *development* of a project disseminated through the NDN is often $500,000 or more, yet the ntire cost of successfully replicating the successes of that project in another local school often costs only a few thousand dollars, sometimes even a few hundred dollars -- costs shared by the Developer Demonstrator, the State Facilitator, and the local school district.

The National Diffusion Network is successful American teachers helping other teachers duplicate their achievements.

'n 1975 about 15,000 teachers, serving some 375,000 students, were trained by National Diffusion Network grantees. By the late-1980s, an average of over 60,000 teachers a year -- in 22,000 schools, reaching an estimated 2,500,000 U.S. school children -- are provided new skills through the training provided by the dedicated staff of validated NDN projects across the country.

The NDN is an enormously effective and cost-efficient system for the improvement of America's schools. Long before the phrase "What Works" became a popular phrase in the Education Department, the National Diffusion Network was proving that school programs that work can be transplanted elsewhere with a *duplication of the same successes* (for example, in student achievement) achieved by the original developer. For the cost of the development of one reading program, a whole school curriculum can be recreated using NDN projects -- as schools have demonstrated in several states across the country.

Not only is the NDN, itself, cost-effective, but it has the extraordinary quality of actually enhancing the cost-effectiveness of other federally-funded education programs! A good example is Chapter I: over the years the National Diffusion Network has made Chapter I a more cost-efficient program in at least two ways. First, to meet an educational need in a particular Chapter I-eligible district, a local administrator can be assured of a successful solution for a very modest investment by adopting one of the dozens of Chapter I-appropriate NDN projects. It would be difficult to calculate how many hundreds of thousands of dollars have been saved because local Chapter I and other federal funds were efficiently used for adoption or adaptation rather than for development.

second way that the NDN has aided a program like Chapter I is by serving as the natural dissemination vehicle for successful programs that *are* developed with Chapter I funds. A rich investment in development is virtually wasted if a new program has a one-time use and is then abandoned; it is analogous to a classic novel that has been created, read by a single person, and then destroyed. New, effective projects, like well-written literature, should be available to all who can -- and wish to -- benefit from them. The NDN serves as the nation's bookstore or lending library of school improvement resources; it is well stocked with dynamic educational tools that might otherwise be unused.

A 1981 Congressional report on the program called the NDN one of the most successful examples of a sound federal investment in education. But this success has been earned at a price. It is the price to participants of maintaining and upgrading a system that has become, with time, seriously underfinanced. The average State Facilitator project grant was $99,000 in 1979; last year it was $92,500, a *reduction* of $6,500 after 10 years. Factoring in the real inflationary increases that each of these projects has faced for staff, travel, and office costs, that $92,500 today is really worth about $31,000. Likewise, in 1979 dollars, today's Developer Demonstrators must make do with grants averaging approximately $20,000.**

Very few business people can resourcefully run a national project on $20,000 a year. And these *are* isinesses. The NDN projects are located in local schools, in state departments of education, in non-profit

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**U.S. Commerce Dept. figures; see attached chart agencies, and in institutions of higher education. But these grantees, like the corner grocery store, are expected to get the job done, pay their staffs and their bills, and come out even by year's end. It isn't easy. Facilitators are expected to meet the increasing demands of local schools throughout an entire state. Imagine attempting to serve all the schools throughout Texas on a State Facilitator budget of $100,000 a year. The incumbent Facilitator in the Lone Star state couldn't. That agency last year declined to reapply for Education Department funding -- it simply could not *afford* to stay in the NDN system any longer.

Developer Demonstrators are expected to be responsive to the needs of schools throughout the whole country. Yet, in real dollars, these projects survive -- and barely -- on an annual amount from the federal government that, in many cases, barely pays the salary and fringe benefits of *one* staff member: that is exclusive of avel, expenses, administration. Each year several veteran Developer Demonstrators decline to reapply for NDN funding. Some seek independent funds instead; others simply close up shop. Our association regularly shares with its members strategies that their colleagues use just to keep their projects afloat. Here are examples: • "Cut staff (to one person)", • "Eliminate *all* secretarial support", • "Job-share with other programs in my agency", • "Diversify our operations (to an extent that it becomes hard to do our primary job)", • "Provide no staff salary increases for the third straight year", • "Work, myself, 20 days last year without pay", • "Eliminate our statewide project newsletter, the only regular link to schools in our large state that we've had". And so on.

Why do these people carry on? There are dozens of veterans in the NDN system, like those of us here this morning, who have stuck it out for a decade or more. As frustrating as it often is, these dedicated educators have jobs where they can make a difference; where their intervention means that a child, who couldn't read before, now can; that an eager but poorly trained teacher now has the tools she needs; that a whole school can be dramatically transformed. These professionals are hooked on the NDN system because it works. But, because of its financial problems, it is not working as well as it could.

Among the other consequences to underfunding of the National Diffusion Network is a serious depletion of e pool of new projects entering the system. For a newly developed program in West Virginia to become validated and part of the National Diffusion Network, it needs to be evaluated and to go through multiple other assessment steps, make several applications, then, if successful at *every* stage, receive a Department of Education grant to do national dissemination work for a total of about $60,000-a-year, which might just pay its basic costs, never mind travel. The first job that is likely to face a new Developer Demonstrator after award of the grant is devising a strategy to raise more funds!

Frankly, there is now simply too little incentive for innovative program developers in schools to go through that process. As a result, although new, exciting programs continue to be developed in our nation's schools, the reservoir of potential new NDN projects is dangerously low. Each year the Education Department provides funds to a special, technical assistance contractor, whose principal job is "search," that is, scouring the country for new programs for the NDN.

Like any retailer, NDN State Facilitators need to be responsive to new customer/school needs. If the newest need is for bilingual instruction in Vietnamese in public schools in Oregon, the Facilitator there wants to be able to respond. In fact, it can't; there are yet no Vietnamese instructional programs in the NDN.

e recognize that we appear before you at a time of enormous concern for the federal deficit and the cost-savings that responsibly accompany our national response to this crisis. Yet, we earnestly request that the National Diffusion Network's budget be increased, at least modestly -- from its current $11.07-million, d its authorized floor of $11.2-million, to $13-million.

Legislation created by Congress in recent years in effect authorizes the National Diffusion Network to become the Department's official program dissemination function for a number of new Education Department initiatives. The authorizing committees have, in effect, said: *As new programs are developed nder these new initiatives, the exemplary practices should be formally disseminated through the NDN.* We are excited with this designation, and, I assure you, our members are eager to welcome into the NDN such newly developed programs. But the infrastructure of the National Diffusion Network will not likely be able to support the added burden which this legislative initiative will naturally create. With essentially no increase n appropriations for a decade, the very viability of the current NDN system is in question. It is unlikely that it can now take on new programmatic responsibilities.

Yet, the education committees of the House and Senate have not yet elected to authorize specific appropriation levels for the National Diffusion Network in each of the places they indicated they wanted the NDN employed. At present, the only place we can go to seek support that will permit the NDN to do its principal work, plus begin to rebuild the system's infrastructure so as to begin the process of preparing for the new programmatic additions, is through the general appropriations for our program.

You can make no better investment in our nation's schools than in the National Diffusion Network. It was created to build upon already-developed success, and it is a success story of its own. But it cannot get the job done at its current level of support.

Our state-based Facilitators get daily inquiries from classroom teachers about the possibilities of adopting an NDN program. Early in the process of these discussions, the State Facilitator works with the teacher to develop a budget, one which usually includes travel and expenses for the Developer Demonstrator trainer, substitute fees, and teacher materials. Far too often adoption of the program of their choice -- given the vailable, combined resources of the State Facilitator project, the Developer Demonstrator project, and the school -- is deemed impossible simply because of cost. We always promise these teachers that we will try to find a solution for this dilemma -- perhaps in a subsequent academic year -- but, in the meantime, the students in that school cannot benefit from an NDN program that would meet their needs.

Too many State Facilitator projects are simply afraid to continue publicizing the existence of their services. Their current resources are exhausted each year by delivery of services to schools that already know about them and are returning for other help or for follow-up assistance. This means that many other schools with real needs in every state are not even being reached by the system designed to provide solutions -- the National Diffusion Network.

The $10-million support for the NDN in 1977 is just not enough for us to do the job in 1989. We *were* able to get the NDN job done effectively in the mid-'70s for the $10-million then provided for that purpose. Factoring in U.S. inflation, that $10-million represents roughly $40-million today. We could get the job done well today with such an appropriation, but recognizing the limitations of resources for education at this time, we respectfully request something far more modest -- an increase to at least $13-million, which would represent one small step toward restoring the support needed to raise the NDN to a position where it .an again appropriately respond to the educational needs in each of our states.

The dedicated NDN program directors and staff throughout the country are prepared to do the work, and America's schools are clamoring for our services. We ask you to arm us with the appropriate means to help them. Thank you.

[Attachments]

NATIONAL DIFFUSION NETWORK

15TH ANNIVERSARY!

1989 Profile

The National Diffusion Network (NDN) is a program of the United States Department of Education, Lauro F. Cavazos, *cretary;* Office of Educational Research and Improvement, **Pat Hines,** *Assistant Secretary;* Programs for the nprovement of Practice, **Milt Goldberg,** *Director;* Recognition Division, **Nelson Smith,** *Acting Director.*

national diffusion network

ndn

The NDN is a nationwide system established to help schools improve through the adoption of locally developed, rigorously evaluated, exemplary educational programs. The NDN has been in operation since 1974, but was first authorized in 1986 by an amendment to Sec. 583 of the Education Consolidation and Improvement Act of 1981. The program was reauthorized by the 100th Congress as part of the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 *[Sec.1562].* The NDN's annual budget has averaged about $10-million, including a high of $14-million in 1979. The final 1989 appropriation is $11-million, just under the 1988 authorized NDN funding floor of $11.2-million. The professional association for NDN participants, the *National Dissemination Study Group,* is asking Congress for a FY90 NDN appropriation of $1[illegible]-million.

State Facilitators

tate Facilitators (SFs) are persons located within each state and funded by the Department of Education to help local hools learn about and adopt Developer Demonstrator programs. There is an SF in each of the 50 states, plus D.C., and Puerto Rico. There is also a **Private School Facilitator** who **assists SFs** with DD entry into non-public schools.

Developer Demonstrators

Developer Demonstrators (DDs) are locally developed, exemplary educational projects approved by a federal panel and funded by the Education Department for the purpose of helping schools improve through adoption and implementation. Since 1987 the Department has also funded **Dissemination Process** projects, large-scale demonstration systems intended to use processes similar to those employed successfully by Developer Demonstrators.

☆ 73 DDs are currently funded. The number of funded DDs each year has ranged from 24 in 1974 to a high of 139 in 1979. Several hundred DDs unfunded by the Education Department are also available to SFs for program adoption in schools. ☆

☆ Over two dozen substantive program areas are covered by DDs, ranging from the basic skills of reading, writing, and mathematics, to adult education, science, special education, and gifted and talented. ☆

COST

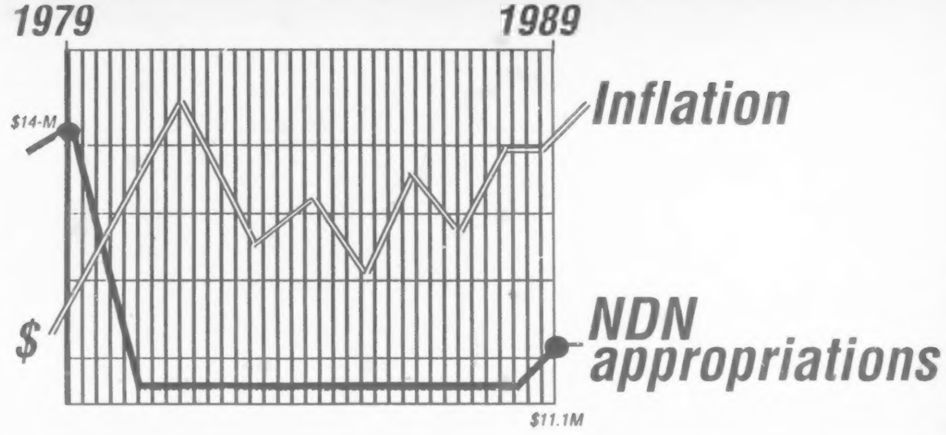
- ☆ Average cost of local development of a typical DD project is **$250,000.**
- ☆ Average cost of adoption of a typical DD project through the NDN is **$800** per school.
- ☆ Matching costs: for every **$1.00** of federal money spent for NDN adoptions, local schools, districts, state education agencies, and other contributors expend **$1.50.**

In one average year –

2,500,000 STUDENTS
learn new skills because of the adoption of NDN programs in their schools.

60,000 TEACHERS
are trained to use DD programs in their classrooms as part of the NDN process.

1989 financial profile of the: NATIONAL DIFFUSION NETWORK



Average 1979 NDN State Facilitator grant: $99,000

Average 1989 State Facilitator grant: **$92,500** → Actual value in 1979 dollars: **$30,800**

Today's average NDN Developer Demonstrator grant in 1979 dollars is worth approximately $20,000

Summary:

As a result of nearly level funding over the past decade, during which inflation has significantly cut the buying power of the U.S. dollar, National Diffusion Network projects have become financially crippled. Several have gone out of business. Nearly all broker service dollars from multiple sources, severely straining already limited staff resources. Almost none are able to meet the demand for NDN school improvement services.

If the NDN is to be able to respond to the educational challenges faced by America's schools in the years ahead -- indeed, if many of its vital components are to survive -- additional appropriations are desperately needed.

The National Dissemination Study Group, the professional association of NDN educators, respectfully requests that Congress appropriate $13-million for the NDN in FY90, an increase of $1.9M from FY89.

Senator BURDICK. I notice that you are getting somewhat of an increase this year over last year, though?

Mr. MCCONKEY. That is correct.

The appropriations were frozen for the NDN for a period of about a decade.

The new reauthorization for the NDN last year enabled the floor for the appropriations to increase to a little more than $11 million. We are asking for a little less than $2 million increase over that $11 million, which, Mr. Chairman, is still, again, $1 million less than the program received a decade ago.

Senator BURDICK. Thank you.

Mr. MCCONKEY. Thank you, sir.

STATEMENT OF SHIRLEY OLSON, EDUCATION SPECIALIST, NATIONAL MILITARY FAMILY ASSOCIATION, INC.

Senator BURDICK. Shirley Olson. You may proceed.

Ms. OLSON. Thank you.

In the interest of time, Mr. Chairman, Sergeant Major McKinney of the Non-Commissioned Officers Association foregoes his appearance here later this morning.

PREPARED STATEMENT OF SGT. MAJ. C.A. (MACK) MC KINNEY

Since our interests are identical, Sergeant Major McKinney joins in endorsing my oral presentation and requests that his prepared statement be made part of the record.

Senator BURDICK. It will so be received.

[The statement follows:]

STATEMENT OF SGT. MAJ. C. A. (MACK) MCKINNEY, USMC (RETIRED)

Mr. Chairman. The Non Commissioned Officers Association of the USA (NCOA) again appeals to this distinguished Subcommittee to recommend full-funding of the authorized sums applicable to the FY 1990 Impact Aid program, originally enacted to provide supplemental funds to school districts impacted with military children.

Public Law 87-874 is a testimonial to the Federal government's responsibility. It states:

> "Congress hereby declares it to be a policy of the United States to provide financial assistance for those local education agencies upon which the United States has placed a financial burden..."

And the Federal government has indeed placed a fiscal encumbrance on military-impacted schools. It has charged the schools to educate military children without the benefit of taxing parents for services received. Though Congress had earlier resolved to fully-fund the program, time and circumstance have led to a funding of less than 50 percent of the entitlement.

Since 1951 the education budget has gone from less than $400 million to more than $18 billion. Yet, Impact Aid funds have risen to less than $800 million in FY 1989. Regular (Section) 3A payments in 1987 have been 40 percent of the amount originally intended by Congress, while Regular (Section) 3B payments were near the 12 percent mark.

It is unfortunate that Congress has had to cut-back on the amount of funds to support the education of military dependent children attending public schools. The result has had an adverse affect on some, many of whom have suffered curtailment of certain educational advantages offered to children in other school districts.

The Reagan-Bush proposal for FY 1990 is regrettably akin to earlier Administration requests. It is far below the fiscal requirement for maintenance and operations and continues to ignore the need to reimburse school districts for the impact of "B" students, as defined in existing statutes. NCOA does not subscribe to the Reagan-Bush theory that "the presence of these ("B") children creates no significant financial burden for local school districts." 1/

Past events have proven that far too many heavily-impacted schools, not only those having "B" students but "A" students as well, have turned away military children whenever Federal funds fall short of expectations. Others threatened to do likewise or impose tuition fees on parents. Some have even gone to court to test their independence from an imposed responsibility that really belongs to the Federal government.

NCOA objects to the use of military children as pawns between the Federal government and local school districts. It is of no small wonder why affected school districts did not want to assume responsibility for operating and maintaining Section 6 schools now under Department of Defense (DoD) authority. They cannot count on the Federal government to fulfill earlier commitments to military-impacted school districts.

In short: "Full funding is essential if the intent of Congress and the obligation of the Federal government are to be met." 2/

However, NCOA endorses the position that: 2/

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1)- DoE FY 1990 Budget Request for Impact Aid, presented by Beryl Dorsett, Asst. Scty. for Elem. & Sec. Ed., before the House Subcmte. on Labor, HHS, and Education Appropriations; Feb. 28, 1989

2)- Final draft, Military Impacted Schools Association position paper for Heavily Impacted School Districts o in order to avoid school closings and program deterioration, it is essential that Congress appropriate no less than the annually authorized amounts of:

	PL 874	PL 815
FY 90	$785 million 3/	$26 million
FY 91	$835 million 3/	$27 million

NCOA appreciates the efforts of this distinguished subcommittee to be fiscally responsible in its funding for military-impacted schools. The Association is aware that its members and staff are committed to an educational program second-to-none. Hopefully, the day will soon arrive when the Impact Aid program for military-impacted schools is fully supported by the federal government.

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3)- To include funds for "B" students

Ms. OLSON. NMFA appreciates this opportunity to express its views on impact aid.

Approximately 2,600 school districts receive impact aid. Of these, 1,334 serve military dependents. Over 552,000 children are educated in these districts.

History shows that these school districts that are highly impacted with military children have been faced with financial crises when impact aid funding is cut or reduced. As late as 1987, the expansion of the Naval Weapons Station Earle in Colts Neck, NJ, was interrupted by a civil suit action.

According to the township, the additional housing units planned would increase the number of students almost 83 percent in 1½ years.

Presently, Colts Neck spends $5,300 per year on each student's education. Federal impact aid funding would offset the cost of the additional Navy children by less than one-half of the per-pupil expenditure.

During times of reduced impact aid funding, not only do military children suffer, but so do their classmates from the civilian community.

Civilian communities heavily impacted with military students cannot afford to subsidize this Federal obligation. Severely strained relations between the military and civilian communities result when the local residents must absorb greater tax burden or the schools must reduce educational services because of inadequate impact aid.

NMFA supports funding for the "b" students. These students do place a financial burden on the local school districts. Since military parents of "b" students are exempt from certain State and local taxes, the Federal Government is obligated to offset the shortfalls caused by insufficient revenue.

The personnel movements associated with base closure and realignment will substantially increase the number of military pupils in some school districts. Public Law 81-874, section 4, provides for the relief when there is such an increase in Federal activity.

The transfer of personnel could start in early 1990. Section 4 is not currently funded.

The influx of federally connected students could also require additional funding under Public Law 81-815, for necessary construction. Funding for these new obligations should not come out of the already curtailed funding for 3 "a" and "b" students.

PREPARED STATEMENT

New obligations placed on school districts by base realignment are Federal obligations. Military impacted school districts and their students should not bear this burden.

In conclusion, NMFA respectfully requests full funding for the impact aid to include payments for the category "b" students.

Thank you.

[The statement follows:]

STATEMENT OF SHIRLEY OLSON

The National Military Family Association (NMFA) is a volunteer organization composed of members from the seven uniformed services, active duty, retired and reserve, and their family members and survivors. NMFA is the only national organization whose sole focus is the military family and whose goal is to influence the development and implementation of policies which will improve the lives of those family members. NMFA appreciates this opportunity to express its views.

Approximately 2,600 school districts receive Impact Aid. Of these, 1,334 serve military dependents. A total of 552,894 military children are educated in these districts.

The volunteer military member is better educated and more likely to be married and have children than ever before. A quality education for their children is of prime importance to military families. Recent surveys show that military families endure long commutes and substandard or extremely high cost housing to assure a proper education for their children.

History shows that school districts highly impacted with miltary children have been faced with financial crises when impact aid funding is cut or reduced.

In 1970, the Bellevue Public School District (Nebraska) closed its doors, terminated one-half of its staff, and cut school programs. Special legislation saved Bellevue and nine of the nation's other most heavily impacted districts from permanent closings.

In 1973, the Douglas School District (South Dakota) closed in April due to lack of funds.

In 1981, Fairfax County (Virginia) informed the Pentagon that it could no longer afford to give free schooling to military dependents. After a lawsuit the County dropped plans to charge tuition to children on Fort Belvoir.

In 1982, the Pemberton (New Jersey) schools voted to bar children of service members from nearby Fort Dix.

In 1982, the Onslow County and Cumberland County (North Carolina) districts attemped to charge tuition, but their action was overturned by the courts.

In 1983, the Sierra Sands District (California) cut out all guidance counseling, reduced programs offered in music and foreign languages, and fired teachers in an effort to live with decreased support from impact aid funds.

in 1983, the Hardin County District (Kentucky) went to the legislature to request that the state allow the district to increase the property tax levy to offset the loss of (b) funds - the same kind of loss that had forced Sierra Sands to cut programs. The state of Kentucky, like so many other states, responded that financial assistance to impacted schools is a federal - not a state - obligation.

In 1984 - 85, the Highland Falls School District (New York) experienced great turmoil over insufficient funds and was forced to form a Section 6 arrangement in order to operate a school.

In 1987, the expansion of the Naval Weapons Station Earle, in Colts Neck, New Jersey was interrupted by civil suit action. According to the township, the additional housing units planned would increase the number of students almost 83% in a year and a half. Presently, Colts Neck spends $5,300 per year on each student's education. Federal impact aid funding would offset the cost of the additional Navy children by less than half the per pupil expenditure.

During times of reduced impact aid funding, not only do military children suffer but so do their classmates from the civilian community. Civilian communities heavily impacted with military students cannot afford to subsidize this federal obligation. Severely strained relations between the military and civilian communities result when the local community must absorb a greater tax burden or reduce educational services because of inadequate Impact Aid.

NMFA supports funding for (b) students. These students do place a financial burden of local school districts. Since military parents of (b) students are exempt from certain state and local taxes, the federal government is obligated to offset the shortfalls caused by insufficient revenue.

NMFA appreciates the attention paid by this subcommittee to funding for PL 81-815, school construction. NMFA has expressed its concerns regarding repair and maintenance of Section 6 schools to the Armed Services Committees. Excluding the 72 DOD Section 6 schools, 114 schools, located on 48 military installations, educating 55,000 children qualify for 815 funding. The health and safety of children in 53% of schools owned by the Department of Education are threatened according to the Dole Report of 1987. NMFA urges this subcommitttee to look at these potentially dangerous facilities when considering appropriation levels.

The personnel movements associated with base realignment will substantially increase the number of military pupils in some school districts. PL 81-874, Section 4, provides for relief when there is an increase in such federal activity. The transfer of personnel could start in early 1990. Section 4 is not currently funded. The influx of federally connected students could also require additional funding under PL 81-815 for necessary construction. Funding for these new obligations should not come out of the already curtailed funding for 3(a) and (b) students. New obligations placed on school districts by base realignment are federal obligations. Military impacted school districts and their students should not bear this burden.

In conclusion, NMFA respectfully requests full funding for Impact Aid to include payments for the catgegory (b) students.

Senator BURDICK. As I understand it, the "a" payments are increased, but the "b" payments are decreased?

Ms. OLSON. Yes, sir.

If there is not sufficient funding, then the "b" students in the districts will receive minimal or no payment at all for "b" students that do create a burden in their communities.

Senator BURDICK. Any questions, Senator?

Senator HATFIELD. No; thank you, Mr. Chairman. I have no questions.

STATEMENT OF MARTHA C. FRICKE, PRESIDENT-ELECT, NATIONAL SCHOOL BOARDS ASSOCIATION

ACCOMPANIED BY:
THOMAS A. SHANNON, EXECUTIVE DIRECTOR
MICHAEL A. RESNICK, ASSOCIATE EXECUTIVE DIRECTOR
EDWARD R. KEALY, DIRECTOR, FEDERAL PROGRAMS

Senator BURDICK. Martha Fricke. Next witness.

Ms. FRICKE. Good morning, Senators.

I am Martha Fricke, president-elect of the National School Boards Association, and a local school board member from Ashland, NE.

NSBA commends the subcommittee for increasing funding for Federal education programs. These programs are a necessary investment in the future well-being of our society, and should not be cut to reduce the deficit.

While President Bush's education initiatives are welcome, his revised budget request does not meet the standard of an "Education President," for it would barely keep pace with the current cost of vital educational services for our school children.

The millions of students at risk of failing in school require a much more serious commitment. Each year, more students come to school with serious barriers to learning. A full quarter of the current enrollment may not finish high school.

Soon these children will make up one-third of the U.S. work force. They cannot succeed in the economy of the 21st century without solid academic and occupational skills.

As never before, our Federal education programs are critical to meeting the needs of these at-risk youth. NSBA recommends increased funding for several key programs, beyond the increase necessary to maintain the effectiveness of all current education programs.

NSBA strongly urges the committee to fulfill the commitment Congress made last year to increase chapter I by $500 million a year until all eligible disadvantaged children are served.

Chapter I has proven itself effective in increasing educational achievement among disadvantaged students. This increase will expand reading and math services to over 600,000 students.

Federal law requires local schools to provide special education services to over 4 million students. Federal funds cover only 7 percent of the extra cost of handicapped education. The new preschool incentive grant program has succeeded in enrolling over 60,000 additional preschool handicapped children, but the administration is recommending a freeze that results in over $100 million shortfall in funding.

Local and State governments cannot make up such shortfalls. NSBA strongly recommends that the committee appropriate at least $300 million above inflation for handicapped children.

NSBA also believes the committee should give increased funding to several other programs for at-risk youth, the new secondary school basic skills and dropout prevention programs, the expanded magnet schools assistance program, and the new even start program.

NSBA also recommends that the committee provide $32 million to restore the cuts made recently to the chapter II targeted assistance programs. These funds have been the lifeblood for countless local school improvement projects across the country.

We also ask the committee to reject the President's request to eliminate funding for impact aid "b" program. Impact aid should receive the full $785 million authorized for fiscal year 1990. This is especially true for me. I live only 30 miles from Offutt Air Force Base, just outside Omaha, and the Bellevue School District is desperate for these class "b" funds.

NSBA requests continued funding for the innovative Star School Satellite Program, and this really hits home. I am in a school district of 750 kids, K–12. We made an application for a grant and received it. We are at this point installing our satellite dish, and we will be able to offer Japanese and Russian to our children next year, and that is very exciting—along with advanced math programs.

The math science teacher training program also deserves increased funding to produce our future scientists. We also support start-up funds for new equipment and facilities under H.R. 7, the Perkins Applied Technology Education Act, which we urge the Senate to pass.

PREPARED STATEMENT

In conclusion, as locally elected and appointed officials, we urge the committee to make a major investment in our young people's education and in the future well-being of America.

Thank you for the opportunity to testify before your committee today.

[The statement follows:]

STATEMENT OF MARTHA C. FRICKE

I. INTRODUCTION

I am Martha C. Fricke, President-Elect of the National School Boards Association (NSBA), and a local school board member from Ashland, Nebraska. I am pleased to have this opportunity to testify before this Appropriations Subcommittee on behalf of the 95,000 local school board members across the country who set policy for the education of our school children.

II. OVERVIEW OF FY 90 FUNDING REQUESTS

NSBA greatly appreciates the steadfast commitment which this Committee has shown toward funding the major federal education programs like Chapter 1 and the Education of All Handicapped Act despite severe budgetary pressures. We firmly believe that the federal government must view education expenditures as a necessary investment in the future well-being of our society and not as a cost to be cut to reduce the deficit.

For Fiscal Year 1990, President Reagan's last budget request called for a mere 1.3 percent increase in spending for elementary, secondary, and vocational education. President Bush submitted budget revisions requesting an additional $430 million for several modest initiatives. This request is an improvement after years of proposals by the Administration for massive cuts in federal education.

However, we must note that, when the effects of inflation are included, President Bush's budget would barely keep pace with the costs of providing the vital educational services in local school districts funded by the federal government.

In addition, most of the President's requests for program increases are offset by proposed cuts, such as the complete elimination of impact aid payments for "b" students, those whose parents either live or work on federal property. The Reagan/Bush request also eliminates funding for the Star Schools satellite distant learning program and for dropout prevention. Further it limits increases on all major programs to less than inflation rates. For example, Chapter 1 basic grants are given only a 1.2 percent increase. And it also freezes the costly preschool handicapped program and the new Even Start program.

While President Bush's spending requests for program initiatives are welcome, they do not meet the standard he set for himself as the Education President. The growing needs of millions of students at-risk of failing in school require a much more serious commitment from the federal government.

III. "AT-RISK" YOUTH AND THE NATIONAL ECONOMY

Elected policymakers, leaders of business and industry, economists and educators all agree that a strong educational system is the key to meeting the economic and social challenges facing our nation.

Yet, each year local school boards are finding a larger proportion of their students are "at-risk" of failing at school.

More and more students show up at the schoolhouse door with one or more serious impediments to learning. Twenty-five percent of kindergartners are from families living in poverty. Fifteen percent have physical or mental handicaps. Fifteen percent are recent immigrants who speak a language other than English. And fourteen percent are children of unmarried parents -- often teenagers. A full twenty-five percent of our students are not expected to finish high school.

Soon these children will make up one third of the United States workforce competing in a world marketplace that puts a premium on increased productivity. Yet without a solid foundation in literacy, computation, and critical thinking skills, these students will be unable to perform up to the standards our economy will demand. Fortunately, our federal education programs, such as those recently reauthorized in the Hawkins-Stafford School Improvement Amendments of 1988, can go a long way to meeting the needs of "at-risk" youth.

IV. EDUCATING FOR THE 21ST CENTURY: SPECIFIC PROGRAM RECOMMENDATIONS

NSBA believes that in the 21st century the basic wealth of a nation will depend less on goods produced or industrial holdings and more on the knowledge base of its citizens. In order to educate for the 21st century, we as a nation must invest today in our school children.

The federal budget must have education as a top priority if our economy is to thrive in the increasingly competitive world marketplace taking shape as we approach the 21st Century.

NSBA asks that the Subcommittee consider our specific recommendations for education funding in FY 90. A summary chart is contained in the appendix for the Committee's convenience.

First, the Committee should maintain the effectiveness of all current education programs by providing an adjustment for inflation to prevent erosion in the federal education program base. The Committee should then fund the following priority areas.

A. Priority Programs for "At-Risk" Youth

We recommend significant real service increases in Fiscal Year 1990 for two programs that deal most directly with "at-risk" youth: Chapter 1 and Handicapped Education.

1. Chapter 1

Chapter 1 has proven itself effective in increasing educational achievement among disadvantaged students. In reauthorizing Chapter 1 in 1988, Congress made a commitment to provide increases of $500 million a year above the baseline until all eligible disadvantaged students are served.

NSBA strongly urges the Committee to fulfill this commitment particularly since it will target at least $227 million of this increase in concentration grants to those students most in need. The Committee should also provide at least a full cost of living increase to all districts not targeted for concentration grants. Despite recent gains in funding provided by this Committee, millions of eligible children across the country are still unserved. This increase will expand reading and math services to about 600,000 additional students.

2. Handicapped Education

P.L. 94-142, The Education of all Handicapped Children Act, requires local schools to provide special education services to over four million students with learning disabilities and physical, mental, and emotional handicaps. The costs of special education are estimated at 2.2 times the average annual per pupil cost of $4,500 or $9,900.

P.L. 94-142 authorizes the federal government to cover 40 percent of the excess costs of fulfilling this federal mandate, but its share has never gone beyond 12 percent and now stands at only seven percent. The President has requested a meager two percent increase for this program -- or only $7 more per child. This represents a further cut in the federal share of costs.

In 1986, Congress expanded the local commitment to the handicapped by requiring participating states to serve all handicapped children ages 3-5 years old by school year 1990-91. Now completing its third year of start-up funding, the Preschool Incentive Grant Program identifies and serves new handicapped children at the local level.

Current figures on the number of children actually participating in this program show that the program has succeeded in identifying and enrolling over 60,000 unserved handicapped preschoolers. In FY 90, the program funding formula converts to a maintenance phase where each state recieves $1,000 per child served in the previous year. Since an estimated 351,000 children are now served an increase of $104 million would be necessary. The Administration has instead recommended a progaram freeze.

Local and state governments cannot make up such shortfalls in special education funding without sacrificing the general educational quality of local schools. NSBA strongly recommends that the Committee appropriate at least $300 million above inflation for two purposes: a) to increase the federal share of excess costs in the basic grant program; and b) to fully fund the commitment made to serve all eligible preschool handicapped children.

B. New Programs for "At-Risk" Youth

The Hawkins-Stafford Amendments also authorize several new or expanded programs that are aimed at improving educational opportunities for "at-risk" students.

The Secondary School Basic Skills and Dropout Prevention Demonstration Programs will allow school districts to design and carry out innovative educational projects for high school students at risk of leaving school without a diploma.

The expanded Magnet Schools Assistance Program will provide many more school districts carrying out school desegregation plans the opportunity to establish quality integrated schools that encourage parental choice and educational excellence. This program should be fully funded before the President's Magnet Schools of Excellence initiative is considered.

The new Even Start Program combines the power of early childhood education with adult education to attack the problem of illiteracy among poor children and their parents.

NSBA believes each of these promising initiatives deserves special consideration by the Committee for increased funding in FY 1990.

C. Other Programs of Special Importance

NSBA also recommends that the Subcommittee provide $32 million for the newly reauthorized Chapter 2 Targeted Assistance

Programs. This amount would restore the unfortunate cuts made in recent appropriations cycles. The Hawkins-Stafford Amendments have targeted Chapter 2 funds on key shool improvement activities such as at-risk youth, effective schools projects, training of staff and school board members and other innovation projects.

Impact aid is essential to local school districts serving children whose parents live or work on federal tax-exempt property. We urge the Committee to reject the President's request to eliminate funding for the impact aid "b" program and instead to provide the full $785 million authorized for impact aid for FY 90.

NSBA also asks the Committee to provide funds for several important programs related to science and technology. Contrary to the President's budget, the new Star Schools Program -- which shows great promise of improving math, science and foreign language education in rural schools through satellite technology -- should continue to receive funding.

The Math/Science Teacher Training Program deserves increased funding especially since the Hawkins-Stafford Amendments greatly improve the allocation of resources to local school districts.

The Congress may soon authorize a new program for the acquisition of equipment and improvement of facilities related to vocational education under H.R. 7, the Perkins Applied Technology Education Act. NSBA asks the Committee to provide start-up funding to allow needy districts in urban and rural areas to modernize their occupational education programs.

V. CONCLUSION

As locally elected and appointed officials, we know that our citizens truly support making education the top priority in the national budget. We urge the Committee to make a major investment in our young people's education and in the future well-being of America.

Thank you for the opportunity to testify before the Committee today.

Appendix

SUMMARY LIST OF NSBA PRIORITIES FOR FY 1990 EDUCATION APPROPRIATIONS

I. Programs for "At-Risk" Youth

1. Chapter 1

$500 million above baseline for basic grants and concentration grants.

2. Handicapped Education

$300 million above baseline for state grants and for full funding of Pre-school Incentive Grants.

3. Hawkins-Stafford Initiatives

New funding for "at-risk" youth initiatives

- Chapter 2 Targeted Assistance Program
- Secondary Basic Skill/Dropout Prevention Demonstration Programs
- Expanded Magnet Schools Assistance Program
- Even Start Demonstration Program

II. Other Programs of Special Importance

Restoration of FY 89 cuts:

- Chapter 2 block grants
- Star Schools

Additional Funding Requests

- Increase Impact Aid to $785 million authorization
- Continue Star Schools program
- Increase Math/Science teacher training program
- Provide funds for Applied Technology Education Act

Senator **Burdick**. Thank you.

Senator, any questions?

Senator **Hatfield**. Mr. Chairman, I would like to just ask one question.

Ms. Fricke, first of all, I want to commend people like you, who are serving on their local school boards.

I know of no more difficult task. You do it gratuitously, and you become the center of an awful lot of frustration from the educational institution and from the public for the costs and all the other things that go with schools.

My field director in Oregon is a former secondary schoolteacher and now is the chairman of a Salem school board, which keeps me very much abreast of your kind of activity and problems.

Frequently, we get a reaction to our requests from this committee to increase educational contributions with the same kind of an argument that I am sure you hear on the local scene, as a member of a school board, and that is, take any period of time as a point of reference, and we have been increasing and increasing the dollars into the school system, at the State level, at the local level, and at the Federal level.

And then, the generalization is, but the quality of our education seems to be going down—or at least the problems and the deficiencies and the crises that we have in different parts of our educational program seem to be either increasing, the quality decreasing, the competition and the contrasting scores are showing us ever on a diminution side of those schedules.

How do you respond to that?

Ms. **Fricke**. Well, sir, I guess I say that the increasing pressures on public schools to educate all children are part of that. We are educating children today that 25 years ago would not have been in the public schools. That strains our money out further. That makes it more difficult. And those children are thrown into the mix.

We also are dealing with a whole different kind of family situation now. We are dealing with the single-parent families. We are dealing with teenage parents. We are dealing with all sorts of things that were not even in the public schools when I was there, and probably when you were there.

It is a whole different world we are living with, and we are doing the very best we can. But it is tough. It is hard.

I just recently served on the panel that picked the youngsters that USA Today honored, just this past Monday, as the outstanding scholars in the United States of America, and I want to tell you, Senator, we are doing an awful good job with a lot of kids.

The things that those youngsters were doing were amazing, and I guess we do not point with pride enough. We take the criticisms, we hear what people are saying, and we say, oh, woe is me, but, quite frankly, I think we are doing a pretty good job in many, many ways. And I am proud of the product of public schools these days.

Senator **Hatfield**. Well, I certainly would agree with you that there are many extraordinary accomplishments.

I think sometimes that we do not develop the advocates group, that we leave it to the teacher and the educators themselves to be their advocates, rather than taking on that as a community responsibility. And sometimes, like the post office, we wonder why they are running in a deficit, and we only judge them on the fact that they are selling stamps, and maybe delivering packages.

We do not take into consideration all the other auxiliary services that they are providing, from registering young people for the draft or for providing civil service test forms.

And in the educational systems, of course, we are teaching our children how to drive. There are those who want to teach them how to pray, and providing all other sorts of social services that are oftentimes outside of the real responsibility of education.

But we are dumping on the schools those that might have been traditionally family responsibilities or community responsibilities.

Ms. **Fricke**. Well, we will do it, Senator, because, you know, we are there.

I think our first concern is always the welfare of the children, and so we will continue to do that, and we will do the best we can. But we need your help.

Senator **Hatfield**. I wish you well.

Thank you, Mr. Chairman.

Ms. **Fricke**. Thank you.

Senator **Burdick**. The next witnesses will be Sharon Percy Rockefeller and David Brugger.

Would the Senator like to be up here, and add to the knowledge?

Welcome to the committee.

STATEMENT OF DAVID J. BRUGGER, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

ACCOMPANIED BY SHARON PERCY ROCKEFELLER, NATIONAL ASSOCIATION OF PUBLIC TELEVISION STATIONS

Ms. **Rockefeller**. Thank you, Senator Burdick and Senator Hatfield.

Mr. **Brugger**. Good morning, Mr. Chairman.

I am David Brugger. I am president of the National Association of Public Television Stations.

I am here to support full funding for the Corporation for Public Broadcasting and for the completion of the Federal Government's commitment to our satellite interconnection system in fiscal year 1992.

Now, we are also supporting full funding for the Star Schools Program, for closed captioning for the hearing impaired, and for described television for the blind.

Details of our support are included in our written testimony, and I ask that they be included in the record.

Senator **Burdick**. They will be.

Mr. **Brugger**. I would also like to introduce our other witness, Sharon Percy Rockefeller.

As chairman of the board of WETA television and radio here in Washington, as a member of the board of the Public Broadcasting Service, the board of the West Virginia Educational Broadcasting Authority, and as the former board chair of the Corporation for Public Broadcasting, she has been a very forceful advocate for public television, and I am honored to introduce her today.

Thank you.

STATEMENT OF SHARON PERCY ROCKEFELLER

Ms. **Rockefeller**. Good morning, Senator Burdick and Senator Hatfield.

Thank you for the opportunity to appear before you and before this subcommittee.

The Federal funds which you appropriate through CPB help us achieve our mission through formal education for 1 million adult learners in the United States, and for 23 million schoolchildren.

You are also investing in informal education, through public awareness, community action, childhood development, and vocational training.

The powerful work of the public television outreach alliance has made a significant dent in the problem of illiteracy. A new series called Learning in America, and the AIDS Quarterly have heightened public knowledge of national crises.

The Congress and the Power Game furthered civic understanding of our lawmakers and the legislative process. Programs for our young learners like "Sesame Street," "Reading Rainbow," and "3-2-1 Contact" have had a real impact on preschoolers and older children by introducing them to the fascination of learning, especially math, science, and reading, which we have heard a good deal about this morning.

Public television needs the continued support of this subcommittee, not only to fully fund the regular activities of the Corporation for Public Broadcasting, but also to complete the financing of a satellite interconnection replacement.

Public television appreciates the commitment that this subcommittee demonstrated last year in funding the first year of replacement needs at $56.8 million.

This year, we seek the remaining funds, $143.2 million, to be appropriated for fiscal year 1992.

The current satellite replacement estimate of $227 million could increase substantially if Congress does not appropriate the full authorization or does not complete the $200 million commitment this year.

Public television stations would have to incur interim or long-term financing costs, which could divert millions of dollars sorely needed for programming to servicing a debt incurred in paying for this important delivery system.

These stations have already devoted a good amount of their resources to satellite replacement planning, technological needs, negotiating with the vendors, and preparing a sound business plan for the satellite system.

PREPARED STATEMENT

We are hopeful that this subcommittee will continue to support our very important enterprise by fully funding CPB at $265 million for fiscal year 1992, and the satellite replacement for $143.2 million.

Thank you again for this opportunity to appear before you, and I would be more than happy to answer any questions you may have.

[The statement follows:]

STATEMENT OF DAVID J. BRUGGER

Introduction and Summary

The National Association of Public Television Stations is pleased to provide this testimony in support of public broadcasting funding. Specifically, we support the following appropriations in the FY 1990 Labor, Health and Human Services, Education bill:

- Funding at the fully authorized level of $265 million for the Corporation for Public Broadcasting for FY 1992;
- Completion of the authorized federal commitment to CPB for the public broadcasting satellite interconnection replacement at $143.19 million for FY 1992;
- Full funding for the Star Schools program administered by the Department of Education at $20 million for FY 1990;
- Full funding for closed captioning for television for the hearing impaired and for the Secretary of Education's Fund for Innovation in Education; and
- Funding for the Descriptive Video Service developed by WGBH, Boston, of $1.3 million through the Department of Education's Office of Handicapped Education.

Background

Last year, the Congress completed and the President signed the first stand-alone authorization for public broadcasting in ten years. The result of months of hearings and other discussions of the role of the federal government in supporting noncommercial, educational television and radio service, Public Law 100-626 provides the important federal foundation on which our industry's plans will rest well into the next decade.

Last year public broadcasting received, in addition to a record level of regular funding through the Corporation for Public Broadcasting, the critical first installment of the funds needed for the replacement of its satellite interconnection system. Before P.L. 100-626 was signed by the President, the FY 1989 Labor, Health and Human Services, Education appropriation was enacted providing CPB with $242.6 million for continuing programs and an additional $56.8 million for the Satellite Interconnection Fund.

The entire public television family — stations, producers, funders, educational institutions, local and state governments, businesses, and viewers — appreciates the support that this subcommittee continues to provide our enterprise. Your unflagging confidence serves to encourage other financial support, widen our audiences, and expand the services that are crucial to our survival.

Public television's mandate: public service programmers

Discussions last year on public television's future brought one important point increasingly to the forefront — that public television's best attributes can be characterized as public service programming.

Federal funds that this subcommittee appropriates annually to the Corporation for Public Broadcasting (CPB) help us achieve these many roles in our broad educational mandate. The federal investment in CPB is at the same time an investment in formal education, public awareness, community action, artistic accomplishment, childhood development, AIDS education, vocational training, and any number of the other goals of this subcommittee.

The ways in which public television has served its individual viewers and their communities, states, and governments with the resources made available to it are nothing short of remarkable. Public television now serves more than 100 million Americans weekly with the MacNeil/Lehrer NewsHour, the highly acclaimed, nightly in-depth news program, and Frontline, the only regularly scheduled prime time documentary series on television; with national and local candidate debates, live coverage of congressional hearings, state legislatures and local government sessions; and with a most extensive schedule of regular and special public affairs programs on television, a schedule that includes Washington Week in Review, Firing Line, Eyes on the Prize, Hedrick Smith's The Power Game and the ninety minute bicentennial documentary The Congress.

Public television provides the only full schedule of broadcast programs for America's children in their homes and classrooms. Programs like WonderWorks, Sesame Street, DeGrassi Junior High, Reading Rainbow, Long Ago and Far Away and Square One TV are hallmarks of our success in providing family educational television free of charge to 97% of this country. Private studies such as one recently released by the University Center for Research in Lawrence, Kansas, have shown that children who watch public television's educational programs develop better reading skills than those who do not. And, a study by the American Library Association showed that children who viewed Reading Rainbow were much more likely to take out library books and read than other children.

Every day, public television teaches nearly 23 million elementary and secondary students with in-school instructional programming that has brought science labs and foreign language classes to the most remote rural school districts. A consortium of eighteen public television state networks in Alabama, Arkansas, Florida, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, North Carolina, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, West Virginia, and Wisconsin as well as local stations in Boston, Cleveland, Detroit, Kansas City, and New York City was a successful applicant for funds under the Department of Education's Star Schools program last year. This group, the Satellite Educational Resource Consortium (SERC), received additional funding from CPB and is now beaming master classes in Japanese, calculus and similar costly subjects to needy schools across the country.

Additionally, we teach "non-traditional" learners — adults who are learning to read, working toward their GED high school equivalency through television programs produced by Kentucky Educational Television, receiving college courses at home funded by CPB's Annenberg project or distributed by PBS' Adult Learning Service, enhancing their job skills, or otherwise enriching their lives.

Public television helps eradicate the barriers of privilege and makes the treasures of cultural heritage and vitality accessible to the American people, regardless of their means, education, social position, or distance from theatres, concert halls, or galleries. Live performance series have showcased American artists from all fields of dance and music. Series like American Masters and the American Experience have highlighted American history and history makers, and the only American drama anthology on television, American Playhouse, has brought home such powerful studies of American courage as A Raisin in the Sun and Stand and Deliver. Both of these shows had tremendous minority audience appeal, with Raisin in the Sun enjoying the highest rating in black households of any show in public television history.

Public television stations have always had special commitments to the communities in which they operate. In recent years these commitments have expanded greatly into nationally coordinated outreach projects on social issues that have made public television virtually a video laboratory for public service. These efforts conducted by public television stations through the Public Television Outreach Alliance have focused on the issues of illiteracy, drug abuse, child care, and AIDS.

Clearly, the federal investment in public broadcasting is at the same time an investment in any of the number of issues that this subcommittee deals with every day.

With the federal support that we have received in previous years, we have taken great strides to serve as the public service programmers envisaged by the framers of the Public Broadcasting Act of 1967. With continued support, we can accelerate and expand these important activities.

Access: Technology needs for program delivery into the next century

In order to ensure the availability of public television programming into the next century, the Congress included authorization for satellite replacement within P.L. 100-626 and appropriated the first installment of the $200 million authorized in last year's Labor, Health and Human Services, Education appropriations bill.

Westar IV, the satellite on which public television's transponders are presently located, will run out of fuel and be retired sometime in 1991. The current system has allowed public television to enlarge the range and scope of its services, ensured the highest technical quality, and greatly increased access to public television programming.

The system that replaces Westar IV must take public broadcasting into the next century, providing all Americans with the level and quality of public television service they presently enjoy, accommodating increased service needs, particularly for high quality instructional programming employing the latest technologies. The Public Broadcasting Service (PBS) and National Public Radio (NPR) have been developing their plans for satellite replacement for almost two years. The members of these organizations, the nation's public television and radio stations, have already committed substantial resources to this effort. Public television is very close to a final decision on the space segment portion of the replacement and is entering the final phase of negotiations with satellite vendors.

Public television estimates that replacement of its satellite interconnection system will cost $172,624,000, which, together with the $53,832,000 that public radio estimates for its replacement system needs, is a total cost of $226,456,000. This estimate does not, however, reflect the substantial prepayment discounts that would be possible if the remainder of the authorized amounts were appropriated for FY 1992. Such discounts could reduce the cost of the system by as much as $17 million.

Even more significantly, this estimate also does not reflect the potentially enormous financing costs that would be incurred if Congress failed to appropriate the full authorization or did not complete the $200 million commitment this year. In that event, public television stations would have to incur interim or long-term financing costs which could divert millions of dollars — dollars critically needed to support public broadcasting services — to financing the debt incurred in paying for the delivery system.

In short, any delay in making these funds available would dramatically increase the total replacement cost without any commensurate public benefit. The burden of any funding shortfall would fall directly on public television and radio stations. Few if any of these stations are in a position to redirect significant funds toward satellite replacement without severely affecting their present programming services, and their ability to provide the important new services that Congress and the American public expect of them.

Of the funds appropriated for FY 1991, the ground system appropriation was intended to provide approximately 50% of the television ground system costs, based on the estimates of those costs that had been provided to the Congress. Assuming a 75%/25% ratio of television and radio transponder costs, we estimate that the net television allocation from the amount thus far appropriated would be a little less than $40 million — a small fraction of the total required to install a public television satellite system adequate to the demand for educational telecommunications in the 1990s.

Although the bad news may be that the needed replacement of the satellite system will be costly, the good news is that replacement affords a unique and timely opportunity to enhance public television's ability to fulfill its public service mission by upgrading its technology and expanding its program distribution capacity. As a nation, this is an opportunity we cannot afford to miss.

Accessibility of its programs to all Americans, regardless of their physical limitations, has been a hallmark of public television's mission since its beginning. Through the creative application of new technology, public television pioneered such achievements as national satellite delivery, stereo sound, closed captioning for the hearing impaired, and now descriptive video for the blind and vision impaired.

We continue to support funding through the Department of Education for television closed captioning. Additionally, we support providing the $1.3 million requested by WGBH, Boston to provide a first season of described programming for the blind and vision impaired through the Office of Handicapped Education. The testing of this new service last fall has been lauded from all quarters as an exciting and effective way to make television programming accessible to the blind. We are hopeful that WGBH can get the federal support it needs to proceed with its plans to institute a regular service of its Descriptive Video Service (DVS).

Conclusion

The federal government has reiterated its support and issued new challenges for public broadcasting in the enactment of P.L. 100-626. We are hopeful that we can continue to rely on the support of this subcommittee toward fully funding CPB and satellite replacement in FY 1992.

We believe that the Congress should renew and enhance its challenge to the citizens, the corporations, and to all other governmental and private funders of public television to play an increasing role in achieving the public policy interests originally hoped for from our communications medium. Through your renewed commitment to this partnership through full funding of this program we will be able to make the best use of the medium that commercial constraints and mass audience appeals will never allow others to do.

Senator **Burdick**. Thank you.

The fund, I notice, last year received $242.1 million, and the President requests $242.1 again.

Ms. **Rockefeller**. That is correct.

Senator **Burdick**. And you are requesting $265 million?

Ms. **Rockefeller**. That is correct.

Senator **Burdick**. The satellite fund was $56.8 million last year, and zero this year? You would like not $56.8 million, but $143.2 million?

Ms. **Rockefeller**. Indeed.

Senator **Burdick**. You could use that money?

Ms. **Rockefeller**. We would put that money to excellent use.

I realize that it looks like a large appropriation, but the thing is that we have to sign an agreement with the vendors now. We are down to the final three.

We have done all the negotiating with the last three. If we could receive the Federal appropriation, we would save $16.7 million in a prepayment discount, it is called.

Otherwise, we would have to go out and borrow money, and in a worst-case scenario, that would come to $95 million.

So, essentially, if we could save the $16.7 million and the $95 million, it would allow us to use that $100 million which would otherwise have to be borrowed and paid off over a long period of time to better and wiser use.

It is a one-time cost. We will not be back for 12 years to ask you again about a satellite system.

Senator BURDICK. Senator, do you have any comment?

Senator HATFIELD. Well, Mr. Chairman, I could not let the opportunity escape me not only to welcome Mr. Brugger here, but particularly to comment on the extraordinary leadership that Mrs. Rockefeller has given to this cause and many other causes throughout her life.

I would just like to make one observation. It seems to me that when we are looking at every possibility to elevate the moral, intellectual, and spiritual character of this country, one has to only look at television to see which part of television is really contributing to the elevation of our intellectual and social well-being.

And I take an area of specialty—the political. When you look at a McNeil-Lehrer news report, as against a 15-second, bite-size summary of the so-called political news, that is the major diet of the American people, you appreciate again the in-depth handling of a complex issue.

Yet, communicating that issue in an extraordinarily high professional manner, as you find in McNeil-Lehrer—I just think it is a very small investment for the social-intellectual influence and impact upon this country.

I also feel that you get the true professional, even perhaps better than from a so-called expert of political science, having been in that field as well. I can say to you that they are probably as biased and opinionated as any so-called group of academicians you might want to find.

I come back again to McNeil-Lehrer as the epitome of objectivity, fairness, balance, and once more, the in-depth handling of the current news of the day.

I just cannot praise too highly the role of public television, not even considering the broad base of the arts and many other aspects of public television.

So I just want to thank you again, Mrs. Rockefeller, for your outstanding leadership and your outstanding contribution to the cause of elevating the basic calibre and character of the American people through public television.

Ms. ROCKEFELLER. May I add one comment?

That is, I assure you we intend to maintain our standards.

Somebody in this country has to set a standard of excellence. We intend to be that broadcasting system.

Second, we will not cease our efforts to incur further private funding. You mention McNeil-Lehrer. I am serving on the Pepsico board of directors right now. AT&T informed us that on July 1 of this year, 1989, they had to cut their commitment to McNeil-

Lehrer from $11 million a year to $5.5 million, and they were searching for another corporation.

At one point, it looked like only a Japanese corporation would help us come in and fund McNeil-Lehrer. I thought that would be—I mean, with all due respect to the Japanese corporations—a sorry statement about our country.

So, I made an appointment with the former chairman of Pepsico, took Mr. Lehrer and Mr. McNeil right to their offices, and with no warning whatsoever, asked them for a 5-year commitment to McNeil-Lehrer.

They gave us $25 million in less than a week. I think, again, they too understand the value of this program and want to do what they can.

So we will raise private money. But especially on the satellite system. We need to come to the Federal Government for this help.

You will more than get it back.

Senator **Burdick**. Thank you very much.

Senator **Harkin**. Excuse me, Sharon, just one second. I was out with some people who testified earlier. There has always been somebody pushing to get advertising on public broadcasting, something I have been adamantly opposed to. I was just wondering what is happening on that front. Are we still OK there, or are we seeing more of a push to do something on advertising?

Ms. **Rockefeller**. No; I would say that the good news is that the feeble efforts which were tried a couple of years ago, when the Federal funds were reduced, to introduce advertising as a reason, in hindsight, to reduce the Federal funds—I mean, it was a solution looking for a problem, really.

There was no problem there. We are not going to allow any further growth in the commercial nature. We have to retain the noncommercial nature of public broadcasting.

It was tried by a couple of stations, but it would totally lose our reason for being. Our raison d'être is to be noncommercial, to not have to report to the marketplace for our soul.

And so I would like to reassure you that that is going nowhere.

Senator **Harkin**. Good. Thank you.

Ms. **Rockefeller**. OK.

Senator **Burdick**. I guess that is it. Thank you.

Ms. **Rockefeller**. Thank you very much.

STATEMENT OF KATHRYN BRICKER, EXECUTIVE DIRECTOR, U.S.ENGLISH

Senator **Burdick**. Kathryn Bricker, U.S.English.

Welcome to the committee.

Ms. **Bricker**. Thank you.

Senator Burdick and Senator Hatfield, my name is Kathy Bricker, and I am executive director of U.S.English.

I am honored to be here today to provide this statement for you.

With more than 350,000 members across the Nation, U.S.English is the largest national organization dedicated exclusively to promoting and protecting English as the common language of the United States.

Last year, U.S.English sponsored three successful and historic State initiatives to declare English the official language of Government.

We are equally proud of our accomplishments in assisting non-English speaking adults to learn English. Without knowing the English language, it is nearly impossible to be competitive in American society.

Therefore, the primary objective of federally funded bilingual education programs should be to give children the most important tool they need to succeed—proficiency in English.

Since 1984, Congress has gradually reduced the restrictions placed on funding methods other than transitional bilingual education. U.S.English worked for and welcomed this increased flexibility for short-term programs based in English rather than in the students' native language.

However, the rationale behind any funding restriction continues to be flawed as long as it is restricted. All educational approaches, so long as they are pedagogically sound, should have an equal opportunity to compete for Federal funds.

To this end, we request that the cap on the percentage of money available to alternative methods be removed.

The bulk of academic research does not support transitional bilingual education as the best method for teaching limited English proficient students. Even supporters of bilingual education have had to admit in recent years that research does not support the effectiveness of transitional bilingual education.

Nationwide, the number of limited English proficient students is projected to increase to 3.4 million in the year 2000, although estimates do range widely.

Whatever the exact figure, it is obvious that the present level of spending is insufficient. U.S.English seeks full funding to teach English to all limited English proficient students as long as the cap on alternative methods is removed and programs are evaluated on their main objective of English-language acquisition.

The most important improvement in the past few years in bilingual education is that more funds are now available to more effective teaching methods. Prior to the 1989 reauthorization, 96 percent of the funds granted to local educational agencies were restricted for transitional bilingual education.

Only 4 percent of the funds were available to other methods of instruction, such as English as a second language and sheltered English.

Congress and the administration then allowed 25 percent of the funds to be used for English as a second language method. This is still not enough. All educational agencies should be given the opportunity to compete on a fair and equitable basis for Federal funds.

Programs should be compared so that the best of the programs receive funding. To do otherwise amounts to uncompetitive prejudice with no basis in research results or in the learning of the students.

We must open the process to fair competition that our young students deserve, notwithstanding the entrenched rigidity of some educational professionals.

PREPARED STATEMENT

In closing, I want to assure you that U.S.English will continue to work to play a constructive role in the dialog on bilingual education.

We commend you and the members of the committee for addressing this important issue.

I would be happy to answer any questions.

Senator **Burdick**. Thank you.

Senator, any questions?

Senator **Hatfield**. No questions.

Ms. **Bricker**. Thank you.

[The statement follows:]

STATEMENT OF KATHRYN BRICKER

Mr. Chairman and Members of the Committee, my name is Kathryn Bricker, and I am the Executive Director of U.S. English. I am pleased to testify on the fiscal year 1990 budget for Bilingual Education.

With more than 350,000 members, U.S.ENGLISH is the largest national organization dedicated exclusively to promoting and protecting English as the common language of the United States. For the past six years, we have demonstrated to the American public the dangers of a policy that fragments our society along language lines.

Last year, U.S.ENGLISH sponsored three successful and historic state initiatives to declare English the official language of government. We are equally proud of our accomplishments to assist non-English speaking adults learn English. Through our "Project Golden Door" we continue to demonstrate cost-effective methods to teach English to adults at the workplace, at community and social service centers, and through Spanish language radio. English is the golden door to oppor-tunity, and to full economic and political participation in this country.

Recognizing the vital role our common language plays for both the individual and society, we maintain that the knowledge of another language is also useful. Recently the National Association of Governors recommended that, to be competitive in the global economy, Americans should teach foreign languages to their children. U.S.ENGLISH concurs with this recommendation. Many of the 350,000 people who have joined our organization know a foreign language and recognize the value of linguistic diversity.

However, in these times of budget deficits and fiscal conservancy, and overall concern about educational attainment of basic job skills, public funding to make American children proficient in two or more languages may well be shifting resources from those who need it most. Today half of all children in California public schools have a native language other than English. Ensuring that these and other children learn English is our greatest educational challenge for the future.

Without English, it is nearly impossible to be competitive in

American society. A recent survey of the American workforce revealed that on average a non-English speaking Hispanic male, even though he has 12 years of schooling and 20 years work experience, will earn an average of 43% less than a male with top English language skills. (McManus, Gould, and Welch, "Earnings of Hispanic Men: The Role of English Language", Journal of Labor Economics Vol.I(2), April 1983, pp. 101-130.) This clearly dramatizes the importance of English skills for economic success in American society. Given this, the primary objective of federally funded bilingual education programs should be to give children the most important tool to succeed in American society -- proficiency in English.

Since 1984 the Congress has gradually reduced the restrictions placed on funding methods other than transitional bilingual education. U.S.ENGLISH worked for and welcomed this increased flexibility. However, the rationale behind the funding restriction continues to be flawed. All educational approaches, so long as they are pedagogically sound, should have an equal opportunity to compete for federal funds.

To this end, we request that the cap on the percentage of money available to "alternative methods" be removed.

More and more evidence supports the notion that an English-based curriculum is as -- if not more -- effective than transitional bilingual education. In the most recent court decision (Teresa P. v. Berkeley Unified School District), a school district's English-based curriculum was tested and deemed as or more effective than transitional bilingual education in teaching limited-English proficient students. Judge Lowell Jensen of the federal district court for the 9th Circuit found that English as a Second Language programs had a sound basis as a modality that enabled children to succeed in their studies. Other federal cases in this area have similarly determined tt local school districts' English as a Second Language programs are effective.

Dr. Christine Rossell, a noted expert on educational methodologies states,

> In second language learning 29 percent of the studies show transitional bilingual education to be superior, 21 percent show it to be inferior, and 50 percent show it to be no different from submersion -- doing nothing. Altogether, 71 percent show TBE to be no different or worse than the

supposedly discredited submersion technique." (The Effectiveness of Educational Alternatives for Limited English Proficient Children in the Berkeley Unified Schoool District, A paper presented at the Public Policy Conference on Bilingual Education, Washington, DC, April 13, 1989, Dr. Christine Rossell)

The bulk of research does not support TBE as the best modality for teaching limited-English proficient students. (P. Engle, Language medium in early school years for minority language groups, 45 REV. OF EDUC. RES. 283 (1975; N. Epstein, LANGUAGE, ETHNICITY AND THE SCHOOLS: POLICY ALTERNATIVES FOR BILINGUAL-BICULTURAL EDUCATION (1977) (Institute for Educational Leadership, Washington, D.C.); I. Rotberg, Some legal and research considerations in establishing federal policy in bilingual education, 52 HARV. EDUC. REV. 149 (1982), Baker and de Kanter, supra note 7; R. Venezky, Non-Standard Language and Reading - Ten Years later, in THE SOCIAL PSYCHOLOGY OF READING, (1981, J. Edwards, ed.)(Institute of Modern Language, Silver Spring, Maryland).

Even supporters of bilingual education have had to admit in recent years that the research does not support the effectiveness of trans-itional bilingual education. (K. Hakuta, Mirror of Language, p.219).

Given the research supporting English-based alternative methods and the lack of evidence supporting bilingual education, there is no longer any justification for Congress to restrict funding of alternative methods of instruction for LEP students. With today's tight budgets at all levels of government, there is simply not enough money to assure that those who need English training will receive it. Removing the cap will inevitably result in more money for the best programs. Given the cost differential between ESL and native-language based programs, limited federal funds would improve education for a greater number of LEP students. Above all, funding should follow management and should be contingent on results.

Nationwide, the number of limited-English proficient students will increase from 2.4 million in 1985 to 3.4 million in the year 2000 (Oxford R., et al. (1981) Projections of non-English language back-ground and limited-English proficient persons in the United States to the year 2000: Educational planning in the demographic context. NABE Journal,5(3), 1-29). The National

Education Association and other organizations have placed the figure at 4.5 million such students. Whatever the exact figure, it is obvious that the present level of spending is insufficient.

U.S.ENGLISH does not seek to reduce the level of funding, provided the cap which restricts funding alternative methods is removed. On the contrary, U.S.ENGLISH seeks full funding to reach all limited-English proficient students -- so long as the cap on alternative methods is removed and programs are evaluated on their main objective of teaching English.

Recognizing that "for every $1 spent today to prevent educational failure, we can save $4.75 in the cost of remedial education, welfare, and crime further down the road," the upfront costs seem justified. (U.S. House of Representatives, "Opportunities for success: cost effective Programs for Children, a staff report of the Select Comm. on Children, Youth and Families," Government Printing Office, Aug. 1985).

The weight of American history argues against bilingual education as the most effective way to teach English to non-English speakers. Transitional bilingual education isolates immigrants from American English-speaking peers; is far more expensive than other mthods without proving to be a superior method; is administratively unwieldy; displaces teachers and politicizes schools.

Mr. Chairman, the most important change we have seen in the past few years in Bilingual Education is that more funds are now available to more effective teaching methods. Prior to 1989 reauthorization, ninety-six percent of funds granted to local education agencies were restricted for"transitional bilingual education." Only four percent of the funds was available to other methods of instruction, such as English as a Second Language, Sheltered English, and structured immersion. The Congress and the Administration decided to allow twenty-five percent of the funds to be used for ESL and other English-based methods. This is still not enough. All educational agencies must be given the opportunity to compete on a fair and equitable basis for federal funds, with none having an unfair advantage. Educational programs should be compared to one another so that the best of all programs receive funding. To do otherwise, amounts to uncompetitive prejudice. We must open up the process to fair competition, that our young students deserve, not withstanding the entrenched rigidity of some education professionals.

In closing, Mr. Chairman, I want to assure you that U.S.ENGLISH and its 350,000 members across the country intend to continue to play a constructive role in the dialogue on bilingual education. We want to commend you, Mr. Chairman, for addressing this important domestic issue. We trust that with the monies carefully appropriated by this Committee, we will see more limited-English proficient children learning English and joining the mainstream of our society.

STATEMENT OF EILEEN D. COOKE, ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN LIBRARY ASSOCIATION

Senator **BURDICK**. Eileen Cooke, American Library Association [ALA].

Ms. **COOKE**. Thank you, Mr. Chairman and Senator Hatfield.

I appreciate the opportunity to testify.

In the interest of saving time, I will try to just highlight some of the points in my testimony.

Federal categorical library programs are in limbo as far as we can see, in trying to understand the Bush administration budget.

Whereas the fiscal year 1990 Reagan budget recommended $137.2 million appropriation, the same as last year's level that Congress provided, however, it was for a new consolidated proposal that has not yet been introduced in Congress.

Meanwhile, there has been a joint House-Senate education hearing on an extension of the Library Services and Construction Act, and at that hearing, nine different witnesses repeatedly pointed out that the current, basically public, library program is working very well. It provides so-called seed money to stimulate better State and local support, and as far as public libraries are concerned, the Federal dollars really represent only about 4 percent, and yet they are very successful with leveraging better State and local investment.

The Higher Education Title II Program has provided vital assistance to academic libraries to acquire scarce resources and encourage interlibrary sharing of resources, and to acquire new technology to expedite the delivery of materials and information and the training of librarians, which is a very critical need right now.

We find that about 15 percent of our library school faculty are 60 years of age, and will be retiring within the next decade, and we are concerned about who is going to train the future information specialists.

We find that the world all understands now that information is important, that it is power, it is money, and meanwhile, we are beginning to lose the very faculty that we need to train the future people.

ALA's recommendations for the various library programs and related programs are attached to my testimony, and they represent for the most part about a 4-percent inflationary factor over current level funding.

In addition, we are urging your support for the $6 million authorization for the White House Conference on Library Information Service, and I am pleased to say that we recognize and appreciate your cosponsorship, the two of you, in seeing that this will be a very important way for the country, State by State, to assess their current resources and see how they can better utilize them, how they can share them more effectively, and to anticipate the information needs of people in the future, whether they are local officials or ordinary laypeople making day-to-day decisions and concerned about their lifelong learning.

Just looking at the cost of resources, when the Higher Education Act was enacted back in 1965, both books and periodical subscriptions were about $8 each.

Now, the average book costs $38.39, and the average periodical subscription $85.39, and that is just average.

PREPARED STATEMENT

We are concerned about how libraries are going to continue to help undergird the education process in this country, especially at the higher education level, when you are talking about numerous doctoral programs where students have to have access to the very latest information.

Thank you very much for this opportunity.

[The statement follows:]

STATEMENT OF EILEEN D. COOKE

My name is Eileen D. Cooke. I am Associate Executive Director of the American Library Association and Director of its Washington Office. ALA is a nonprofit educational organization of 48,000 librarians, trustees, educators, and other friends of libraries dedicated to the improvement of library services.

After six years of zero budgets, the Administration has for the second year recommended federal assistance for libraries. This year the recommended authorization level has increased from $76 million to $137.2 million, the same level as FY 1989 funding for LSCA and HEA II programs. The Reagan Administration budget for FY '90 recommended legislation to replace the current programs, and the Bush Administration sent draft legislation to Congress on March 16.

However, Administration officials, in testimony before your Subcommittee, also said that library programs are in the category of domestic programs being frozen at the FY '89 outlay level, pending negotiations between the Administration and Congress. Thus, it is difficult to determine what is actually being recommended; and in any case, for the current LSCA and HEA II programs, no funds appear in the Bush Administration's budget.

The message from the library community--from librarians of all types of libraries, from trustees and friends of libraries, from state library agencies--is quite clear: the existing programs work well and should be continued and funded adequately. This came through emphatically at a recent joint House-Senate hearing on LSCA reauthorization.

Dorothy Sanborn Elliott, Director of the St. Joseph (Missouri) Public Library said: "...the most important thing for the Congress to do is save LSCA. LSCA grants have, partly through the use of technology, enabled libraries like the River Bluffs Regional Library to cross jurisdictional boundaries, to reduce costs, to broaden access to materials, and to coordinate the purchase of our resources." California State Librarian Gary Strong said: "The California Literacy Campaign would not exist today if there had not been LSCA funds to support our initiatives. This small amount of 'seed' money triggered not only new funding for library services, but assisted local public libraries in diversifying their local programs to meet a tremendous need even before the national attention that literacy is now receiving." These comments are typical of all the witnesses' testimony.

Libraries are a heavily used resource. About 57 percent of adults used a public library at least once in 1987. More than 47 million school students use a school library media center each week. An estimated 12 million college students have libraries available to them. The federal role in support of these libraries is small--amounting to about 4 percent of public library support. Most federal support for libraries falls within your Subcommittee's jurisdiction, and every piece of it is crucial: the Library Services and Construction Act, with its support for public libraries and interlibrary cooperation; the Higher Education Act title II programs for college and research libraries and library training and research; the ESEA Chapter II school block grant which includes school library resources as a targeted area; the National Center for Education Statistics library surveys; the National Library of Medicine, including the Medical Library Assistance Act; the National Commission on Libraries and Information Science; and a special event, the White House Conference on Library and Information Services.

ALA's recommendations for these programs are attached to my testimony; for the most part, we recommend modest increases so that current service levels can be continued. This Subcommittee has provided consistently strong support of libraries, and we ask that you do so once again. In my limited time with you today, I would like to highlight just a few points.

Legislation authorizing a White House Conference on Library and Information Services was signed into law last August, too late for the FY 1989 funding process. However, the conference is to be held by September 30, 1991. The $6 million authorized in PL 100-382 is urgently needed in FY 1990, because the availability of funds in October 1989 (at the earliest) would leave less than two years for planning and holding the conference. The authorized funds would be used one-third for state preconference activities, one-third for central support, and one-third for the national Conference.

Meanwhile, several states have already received approval to plan Governors' Conferences or other preconference activities such as surveys of needs in the states for improved library and information services. But states hesitate to move forward without federal funding and guidelines. The statutory White House Conference Advisory Committee is almost complete in its appointments, and has met once with private funding. Further private assistance is dependent on assurance of a federal commitment.

The suggested themes for the White House Conference are library and information services for productivity, for literacy, and for democracy. These themes will enable the Conference to identify unmet service needs, examine critical issues, and develop recommendations. The 1979 White House Conference made 64 recommendations, of which 55 have been wholly or partially implemented. It is time now for a second reassessment, and for the high-level attention to libraries that only a White House Conference can bring.

I would like to emphasize the LSCA II public library construction program because this is an area the Administration's proposal would eliminate. Department of Education officials say that the federal share of LSCA II projects is now only 6 percent, and, therefore, federal assistance is not necessary. Most librarians would emphasize, instead, the dramatic effect that a small federal grant can have! LSCA II generates local incentive and matching funds; many states choose to spread the available federal dollars among as many communities as possible who have demonstrated a need and a commitment.

At the LSCA reauthorization hearing, Jane Hatch, Director of the Southwest Kansas Library System, said: "In Kansas 87% of the public libraries are located in communities of under 5,000 population and 45% are located in communities of under 1,000. These towns have little possibility for library construction without LSCA Title II. I have seen amazing results in towns like Minneola where a construction grant transformed the town attitude from defeatist to energized due to the successful, visible main street project." She emphasized that "The grant gave the librarian the hope to dream, gave the community a goal to rally around and validated the worthiness of the project through the statewide application process."

Slated also for elimination in the Administration's proposal are programs targeted to college and research libraries and library training. The testimony of ALA President F. William Summers, Dean of the School of Library and Information Studies at Florida State University in Tallahassee, emphasized the importance of the HEA II-B fellowship assistance to recruitment in librarianship. The 1988-89 Occupational Outlook Handbook demonstrates a shortage of librarians due to a larger-than-average number reaching retirement age through the year 2000, and also to the drop in the number of graduates of master's degree programs. In 1974 there were 6,370 graduates in library science; in 1986 there were 3,538. The number of minority librarians with master's degrees declined 40 percent between 1979 and 1984, paralleling the decline in HEA II-B funding.

Shortages of librarians are expected to continue through the end of the century in certain areas of strong demand, including children's and young adult services, school librarianship, cataloging, and minority studies and services. In addition, fully 15 percent of the approximately 550 faculty in graduate schools of library and information science are 60 years of age or older. Replacement faculty are essential. At the January meeting of the Association for Library and Information Science Education, only 26 persons were available to fill more than 50 faculty openings.

In summary, the federal library programs under your jurisdiction are a major source of innovative funding, stimulating improved community outreach and encouraging new organizational patterns and the use of new technology to improve services. Continued funding is crucial to the ability of libraries to provide 21st-century services.

ATTACHMENT

SUMMARY OF AMERICAN LIBRARY ASSOCIATION APPROPRIATIONS RECOMMENDATIONS

FY 1990 Labor-HHS-Education Appropriations

Library Programs		FY 1988 Appropriation	FY 1989 Appropriation	FY 1990 Authorization	FY 1990 Admin. Request[1]	FY 1990 ALA Recommendation[2]
Library Services and Construction Act	TOTAL	$125,037,000	$127,165,000	$181,000,000	$ -0-	$132,760,000
Title I, Pub. Lib. Services		78,986,000	81,009,000	95,000,000	-0-	84,573,000
II, Pub. Lib. Construction		22,595,000	22,324,000	50,000,000	-0-	23,306,000
III, Interlib. Coop.		18,669,000	19,102,000	30,000,000	-0-	19,942,000
IV, Indian Libraries		(funded at 2% setaside of appropriations for LSCA I, II, & III)				
V, Foreign Lang. Materials		-0-	-0-	1,000,000	-0-	1,000,000
VI, Library Literacy		4,787,000	4,730,000	5,000,000	-0-	5,000,000
Higher Education Act	TOTAL	$ 10,052,000	$ 10,035,000	$ such sums	$ -0-	$ 21,477,000
Title II-A, College Lib. Resources		-0-	-0-	such sums	-0-	10,000,000[3]
II-B, Training, Research		718,000	709,000	such sums	-0-	1,000,000
II-C, Research Libraries		5,744,000	5,675,000	such sums	-0-	5,925,000
II-D, Technology		3,590,000	3,651,000	such sums	-0-	3,812,000
VI, Sec. 607 Foreign Periodicals		-0-	-0-	such sums	-0-	1,000,000[3]
Hawkins-Stafford Elementary/Secondary School Improvement Act ESEA Chapter 2[4]		508,439,000	490,740,000	610,000,000	507,236,000	512,333,000
National Commission on Libraries and Information Science		718,000	741,000	750,000	770,000	770,000
National Ctr. for Education Statistics (incl. library surveys)		20,953,000	31,122,000	such sums	37,370,000	37,370,000
Natl. Library of Medicine (incl. Medical Library Asst. Act)		67,910,000	73,731,000	such sums	78,229,000	78,229,000
White House Conference on Library and Information Services[5]		---	---	6,000,000	-0-	6,000,000

[1] Administration has submitted legislative proposal with authorization total of $137,200,000 to replace LSCA & HEA II.

[2] ALA recommended funding levels generally include a current services factor of 4.4 percent.

[3] For currently unfunded HEA library programs, ALA recommends amounts authorized for FY 1987.

[4] The six targeted uses of Chapter 2 funds include school library resources and training of librarians.

[5] PL 100-382, signed August 8, 1988, authorized $6 million for a WHCLIS to be held by September 30, 1991.

American Library Association, Washington Office, 202/547-4440

April 1989

Senator **Burdick**. Thank you.

Senator **Hatfield**. Mr. Chairman, may I just comment briefly that there is a part of this budget, the Library Services and Construction Act, that almost has my brand on it, because for the last 8 years, this subcommittee has been very patient and very receptive to my raising the restoration of this project, because 8 years of President Reagan, we either received a request from the administration to excise it entirely, or to substantially reduce it.

Mr. Chairman, I grew up in a time in a very small town, where the name Carnegie was equivalent to library opportunity in a small village, and I do not think anything since that has been more significant to that growing development than the Library Service and Construction Act, for it provides the seed money, the up-front money, and oftentimes the triggering mechanism, for small communities to develop a library facility.

Mr. Chairman, I am troubled, like Barbara Bush and others, that we have a high illiteracy problem in this country.

But I also am aware that last year more Americans purchased videocassettes than checked free books out of public libraries, and that bothers me deeply, because of the fact that I think that not only contributes to the literacy problem that we have, but also it again is neglecting the development of the mind, both visually as well as through the written word.

I want to make that comment to indicate to you, Ms. Cooke, that I will attempt again to get this subcommittee, as it has been so receptive, and Senator Burdick has been one of the staunchest supporters, and I know Senator Harkin as well—that that zero on the Library Services and Construction Act from the OMB should be filled as closely as possible to the authorized level, and to the recommendation level.

I want to commend you for providing the public with an excellent service.

Ms. **Cooke**. Thank you very much, Senator. We deeply appreciate the leadership that you exercised, and certainly Senator Burdick who has also helped us with postal appropriations to maintain postal books going out to people in remote areas.

Senator **Burdick**. I want to thank my colleague for the plug, but the real facts of life are these.

My mother, in Williston, ND, was chairman of the library committee in Williston. I had no choice. [Laughter.]

Ms. **Cooke**. Thank you.

Senator **Harkin**. Thank you.

STATEMENT OF NIEL EDMUNDS, PRESIDENT, AMERICAN VOCATIONAL ASSOCIATION

Senator **Burdick**. Dr. Neil Edmunds, American Vocational Association.

Dr. **Edmunds**. Good morning, Senator Burdick and Senator Hatfield.

I am Niel Edmunds, president of the American Vocational Association. I appreciate this opportunity to appear today on behalf of vocational educators and the more than 19 million students that we serve to support the appropriations for the Carl D. Perkins Vocational Education Act.

Today, vocational education is vital. Its image is improving, and it is providing relevant education and training for tomorrow's workforce.

This is due in no small part to the Federal investment made possible by the Carl D. Perkins Vocational Education Act and the leadership of this committee in providing assistance to fund the act.

Mr. Chairman, the Federal investment in vocational education pays. In my own State of Missouri, a longitudinal study was conducted following Missouri high school graduates.

Among the major findings when compared with nonvocational graduates who went immediately into the workforce, vocational graduates earned more, had more job stability, were more likely to be employed, and indicated more job satisfaction.

There is national data to support this as well. Dr. John Bishop of Cornell University recently completed research as part of the required national assessment of vocational education. His specific focus was with the disadvantaged students. This is what he found.

Taking one vocational course each year during 4 years of high school raised the graduation rates of at-risk youth by 6 percentage points, thus lowering dropout rates.

The economic benefits of high school vocational education for minority youth were substantial, especially for Hispanic youth. When a trained job was obtained, monthly earnings were nearly 10 percent greater, unemployment substantially reduced, labor force participation more consistent, and productivity on the job increased.

These research findings all point to a need to increase our public investment so additional public dividend can be realized.

But now, Mr. Chairman, these researchers have been joined by another group with impressive credentials in the area of policy development. They are the members of the U.S. House of Representatives.

In passing H.R. 7, and suggesting new areas of involvement for vocational education, the House has joined many others in calling for increased Federal investment. With near unanimous bipartisan consensus, the House has approved new authorization levels which realistically address the needs of vocational education for fiscal year 1990.

The American Vocational Association urges this committee to appropriate at least these amounts approved in H.R. 7. We applaud and welcome this action, but do have concerns about the funding formula recommended and other matters relating to State assistance.

For fiscal year 1990, AVA recommends an appropriation of $1,144,300,000 for existing programs of the Carl D. Perkins Vocational Education Act, and further urges the committee to reserve an additional $300 million for two new initiatives authorized by H.R. 7—tech prep education for $200 million and the improvement of facilities and equipment at $100 million, making a total of $1,444,300,000.

Mr. Chairman, the specific recommendations are detailed in the chart attached to our written statement, but in short, they are as follow: Title II basic State grants, $1 billion; assistance to community based organizations serving disadvantaged youth, $15 million;

consumer and homemaking education, $40 million; business/labor education partnerships, $20 million; national programs including research, demonstration, and data systems, $29 million; bilingual vocational training, $10 million; and career counseling and guidance, $30 million.

PREPARED STATEMENT

Mr. Chairman, this concludes my remarks, and I will answer any questions that you may have.

Thank you.

Senator **Burdick**. So that we do not have any confusion here, the figures you quoted for the House are not appropriations—they are authorizations, are they not?

Dr. **Edmunds**. Pardon?

Senator **Burdick**. They are not appropriations, they are authorizations.

Dr. **Edmunds**. Right.

Senator **Burdick**. That is all.

[The statement follows:]

STATEMENT OF NIEL EDMUNDS

I am Dr. Niel Edmunds, President of the American Vocational Association (AVA) and Coordinator of Industrial Education at the University of Missouri-Columbia. I appreciate the opportunity to appear today on behalf of vocational educators -- and the more than 19 million students we serve -- to support appropriations for the Carl D. Perkins Vocational Education Act.

Founded in 1926, AVA is the nation's primary professional organization with a full-time commitment to help vocational educators and institutions provide effective programs to prepare students for the world of work. Our membership -- now some 45,000 strong-- represents teachers, administrators, researchers, and counselors at the secondary, postsecondary, and adult education levels.

Today vocational education is vital, its image is improving, and it is providing relevant education and training to tomorrow's workforce. That is due in no small part to the Federal investment made possible by the Carl D. Perkins Vocational Education Act and the leadership of this Committee in providing assistance to fund the Act.

Mr. Chairman, the Federal investment pays.

In my own State of Missouri, a longitudinal 5-year study was conducted following Missouri high school graduates. Among the major findings, vocational graduates, when compared with non-vocational graduates who went immediately into the workforce: earned more, had more job stability, were more likely to be employed, and indicated more job satisfaction.

But there is national data as well. Dr. John Bishop, with the New York State School of Industrial and Labor Relations of Cornell University, recently completed research as part of the National Assessment of Vocational Education required by the 1984 Perkins Act. His specific focus was on disadvantaged students. Here is what he found:

1. Taking one vocational course each year during four years of high school raised the graduation rates of at-risk youth by 6 percentage points, thus lowering dropout rates.
2. The economic benefits of high school vocational education for minority youth were substantial, especially for Hispanic youth.
3. When a training related job was obtained, monthly earnings were nearly 10% greater, unemployment substantially reduced, labor force participation more consistent, and productivity on the job increased.

These research findings all point to a need to increase our public investment so additional public dividends can be realized. But now, Mr. Chairman, these researchers have been joined by another group with impressive credentials in the area of policy development: Members of the Education and Labor Committee of the U. S. House of Representatives. In reporting H.R. 7 for House consideration and suggesting new areas of involvement for vocational education, the Committee has joined many others in calling for increased Federal investment. With unanimous bipartisan consensus, the Committee has approved new authorization levels which realistically address the needs of vocational education for FY 1990. We believe the entire House of Representatives will soon concur. While there are a number of concerns with H.R. 7 which AVA shares with other groups and hopes to address effectively in the Seante. the American Vocational Association urges this Committee to appropriate those authorization amounts approved in H.R. 7.

For FY 1990, AVA recommends an appropriation of $1,144,300,000 for existing programs of the Carl D. Perkins Vocational Education Act and further urges the Committee to reserve an additional $300 million for two new initiatives authorized by H.R. 7 -- Tech-Prep Education ($200 million) and Improvement of Facilities and Equipment ($100 million) for a total of $1,444,300,000.

WHAT AVA IS RECOMMENDING

Mr. Chairman, AVA's specific recommendations are detailed in the chart attached to our written statement. The amounts we suggest are generally in line with those unanimously approved by the House Committee on Education and Labor. In short, they are as follows: For Title II-Basic State Grants - $1 billion; for Assistance to Community-Based Organizations serving disadvantaged youth - $15 million; for Consumer and Homemaking Education - $40 million; for Business-Labor-Education Partnerships - $20 million; for National Programs, including Research, Demonstrations, and Data Systems - $29.3 million; and for Bilingual Vocational Training - $10.0 million.

Mr. Chairman, this concludes my remarks. Time does not allow me to elaborate in greater detail regarding our recommendations but I would be delighted to answer any questions you may have.

AMERICAN VOCATIONAL ASSOCIATION RECOMMENDATIONS
FOR FY 1990 APPROPRIATIONS
FOR THE CARL D. PERKINS VOCATIONAL EDUCATION ACT

Program	AVA Recommendation
State Grants	
Basic State Grants	$1,000.0 million
Special Programs	
Community-Based Orgs.	$ 15.0 million
Consumer and Homemaking Ed.	40.0 million
Guidance and Counseling	30.0 million
Business-Labor-Ed Partnerships	20.0 million
National Programs	
Research	7.6 million
Demonstrations	15.5 million
Data Systems	6.2 million
Bilingual Training	10.0 million
SUBTOTAL	$1,144.3 MILLION
New Programs	
Tech-Prep Education	200.0 million
Facilities and Equipment	100.0 million
TOTAL	$1,444.3 MILLION

STATEMENT OF SCOTT MARSHALL, COALITION ON TECHNOLOGY AND DISABILITY

Senator **Burdick**. Scott Marshall, Coalition on Technology and Disability.

Welcome to the subcommittee.

Mr. **Marshall**. Good morning, Senator Burdick.

Good morning, Senator Hatfield.

My name is Scott Marshall. I am representing today the Coalition on Technology and Disability, a group of about 100 national and community organizations as well as professionals and administrators of programs dedicated to sound public policy in the area of technology assistance for people with disabilities.

I would like to share with you the progress that we have made and the momentum we have achieved since passage of the Technology-Related Assistance for Individuals with Disabilities Act, which was passed by Congress last session.

My personal perspective, gentlemen—I am a technology user myself. Technology for people with disabilities can be simple, low-tech, like a foam ball with a pencil through it, which allows a person with arthritis to write. Or it can be a specially modified cassette tape recorder, like this one, which enables a blind person to, if you will, speed-listen to audio cassette material.

I am fortunate in that I work in an area that gives me access to information about technology. I also have an income that allows me to purchase some of these devices.

Unfortunately, the vast majority of disabled people in the United States are not in that situation, and the tech bill, as we call it, was designed to bridge the gap between technological innovation, consumer awareness, and access.

The application competition for the first-year funding of the State grant program under this act will take place later this summer.

Some of the really innovative and worthwhile projects that are being considered are things like these: Use of mobile vans to bring technology evaluations to people with disabilities where they live in rural areas; and use of a State university television system to provide information about technology, for just two examples.

Unfortunately, the provision of technology involves more than simply just buying a device. It involves providing information about what is out there, providing training and evaluation, and even looking at how these devices can be financed through existing or new mechanisms.

The coalition recommends, therefore, that title I of the act be funded at $20 million for fiscal year 1990, which will allow us to have up to 20 States to receive as much as $1 million in grant funds to establish these consumer-responsive assistance programs in each State.

In addition, title II, which relates to programs of national significance, should be funded at a level of $6.5 million, so that activities authorized under that title can also begin.

One very major activity is to examine the impediments that we now face toward the acquisition of needed technologies in a variety of systems—the tax system, the medicare system, et cetera.

PREPARED STATEMENT

We need to look at all of these areas so that we can find out what we need to do in making technology more accessible to people with disabilities through existing programs as well as new, innovative approaches.

That concludes my statement, gentlemen, and I would be happy to answer any questions.

Senator **Burdick**. Thank you for your contribution this morning. Thank you.

Mr. **Marshall**. Thank you, sir.

[The statement follows:]

STATEMENT OF SCOTT MARSHALL

My name is Scott Marshall. I am Director of Governmental Relations for the American Foundation for the Blind. Today I am speaking on behalf of the Coalition on Technology and Disability regarding Fiscal Year 1990 appropriations for programs authorized under Public Law 100-407, the Technology-Related Assistance for Individuals with Disabilities Act of 1988.

The Coalition on Technology and Disability is composed of over one hundred national and community based organizations, professionals and program administrators, who represent the diverse interests and needs of parents, children and adults with disabilities. These organizations have joined forces to improve public policy in the area of assistive technology, to close the gap between technological innovation, consumer awareness and access to assistive technology devices and services.

With the passage of P.L. 100-407, Congress acknowledged the powerful role that assistive technology can play in the lives of people with disabilities. Assistive technology may be as simple as a pencil stuck through a foam ball to allow someone with arthritis to write, or an undershirt with Velcro fasteners down the front to make it easier for a person who has had a stroke to dress. Technological advances make it possible for people with speech impairments to communicate using a computer synthesized voice, or for people with language problems to develop writing skills with special word processing programs; individuals who are paralyzed can use their voices to activate an environmental control system to operate light switches and other appliances in the home.

These aids and devices help people with disabilities to perform many activities independently which previously required assistance from family, friends and others. Assistive technology will enable many of these individuals, for the first time, to communicate, control their environment, seek competitive employment, or benefit from educational programs.

At Congressional hearings on assistive technology held last spring, an official from the Department of Education stated that "the provision of technology to persons with handicaps is currently characterized by a fragmented service delivery system in which the purchase of technology, the delivery of technology, and information about technology are not integrated into a mutually reinforcing and complementary whole. Rather, a very inefficient, uncoordinated approach to the provision of technology exists."

Service delivery for assistive technology is not simply a matter of purchasing a device and handing it to the person who is supposed to use it. It requires information, an ability to provide appropriate evaluation and training, and knowledge of the complex financing and reimbursement systems - both public and private.

An individual's need for an assistive device is usually life long: if you need an augmentative communication device as a child, you will probably continue to need an augmentative communication device as you grow up, graduate and go to work.

This requires coordination among the various state and local agencies and diverse service organizations to ensure that individuals requiring the use of assistive technology will continue to have access to appropriate devices and services as they make the transition from one environment or delivery system to another.

P.L. 100-407 has served as an incentive for states to begin to address these issues. The legislation has already had an impact on technology-related services in the states. In anticipation of the state grant program, many state and local agencies and community-based organizations are working together and sharing information on existing resources and services, as well as identifying gaps or problems in the current service delivery system. In some states coalitions and networks have formed around this issue. These groups are proving to be valuable sources of information on who is providing assistive technology services in the community, and successful problem-solving strategies.

Many states will be unable to build the capacity to provide assistive technology services, however, without the additional resources available through the Title I program. Fiscal year 1989 appropriations for Title I fell short of the authorized level: up to eight states will receive technology-related assistance grants in 1989; the Act authorizes ten states. We understand from officials at the Department of Education that over 30 states intend to submit proposals for the grant competition this year.

The success of this effort depends on the full participation and cooperation of the states in developing consumer responsive, statewide programs of technology-related assistance. Without such a system, individuals with disabilities will continue to be denied the tools they need to benefit from a free and appropriate education, seek gainful employment and participate fully in society.

We respectfully submit the following recommendations regarding FY '90 appropriations for assistive technology programs:

1. The Coalition recommends $20 million to be appropriated in fiscal year 1990 to carry out TITLE I: GRANTS TO STATES. This amount would assure that:

a) states receiving development grants in FY '89 will be able to carry out the second fiscal year of the grant program;

b) up to twenty states (including continuation grants) will be awarded Title I grants of up to $1 million for the second fiscal year of the program, as authorized under this Act;

c) funds will be available to provide technical assistance to states as they begin to develop consumer-responsive, statewide programs of technology-related related assistance, and to states requiring assistance in developing grant proposals; and,

d) the Department of Education is provided with adequate resources to conduct quality peer reviews and site visits.

2. The Coalition recommends $6.5 million to be appropriated in fiscal year 1990 to carry out TITLE II: PROGRAMS OF NATIONAL SIGNIFICANCE. Title II programs address barriers that impede access to assistive technology devices and services. For example, current policies for financing and reimbursement for assistive technology are major barriers for people with disabilities, and must be studied on a federal as well as state level. Title II also supports the development of best practices in assistive technology through model demonstration and innovation projects. These activities are of critical importance to the States as they begin to resolve serious systemic problems concerning service delivery of assistive technology.

We believe that $26.5 million is needed to ensure meaningful participation by the twenty states authorized by Congress to receive technology-related assistance grants in fiscal year 1990, and to address Title II programs.

Certainly the disability community believes that any figure below the Reagan/Bush recommendation of $10.7 million would destroy the momentum established by the passage of this important legislation and would, for all practical purposes, prevent the federal government from serving as a catalyst for increasing the availability of assistive technology devices and services.

Mr. Chairman, that concludes my remarks. The Coalition commends you for your leadership on this issue, and appreciates the opportunity to testify on this important new program.

STATEMENT OF JANET LIEBERMAN, LEGISLATIVE DIRECTOR, U.S. STUDENT ASSOCIATION

Senator **Burdick**. Janet Lieberman, legislative director of the U.S. Student Association.

Welcome to the committee.

Ms. **Lieberman**. Thank you, Mr. Chairman and Senator Hatfield.

I am Janet Lieberman, legislative director of the United States Student Association [USSA].

USSA is a national membership organization representing students attending diverse colleges and universities around the country. Our primary goals are to increase access to postsecondary education and improve educational opportunity for all individuals in our Nation.

I am very pleased to appear before you to present USSA's recommendations for higher education appropriations for fiscal year 1990.

Pell grants are the cornerstone of the Federal financial aid programs. An estimated 82 percent of Pell grant appropriations go to students with adjusted family incomes of $15,000 a year or less.

Unfortunately, the purchasing power of the maximum Pell grant has dropped by 30 percent since 1980, when adjusting for inflation and increased college costs.

USSA strongly supports fully funding Pell grants with an increase in the maximum grant to $2,500 in fiscal year 1990.

USSA also urges you to fund the Pell grant program fully to allow newly eligible less-than-half-time students to receive aid without a reduction in aid to full and half-time students.

USSA recommends investing $5.1 billion in Pell grants for fiscal year 1990.

TRIO programs—special programs for disadvantaged students, enable low-income, first generation to attend college and physically challenged students to attend college.

As last year's hearings on guaranteed student loan defaults showed, lack of educational success is a major factor leading to loan default. TRIO programs do what no other Federal aid programs can: Help those most at risk of educational failure to achieve success in school.

The number of students served under TRIO has declined 13 percent since 1980, when adjusting for inflation.

USSA urges Congress to fund TRIO at $265.5 million in fiscal year 1990, to ensure a 15-percent increase in the number of TRIO students served, unfortunately, still less than 10 percent of the eligible population.

College work-study, supplemental educational opportunity grants—SEOG—and State student incentive grants [SSIG] allow financial aid administrators the flexibility to award relatively small amounts of aid to students needing additional financial assistance.

Unfortunately, from fiscal years 1980 to 1989, when adjusting for inflation, we see that college work-study funding has declined 24 percent, SEOG 18 percent, and SSIG 46 percent.

USSA supports appropriation increases to keep pace with inflation and to begin to restore the depleted funding.

Regarding title IX, racial minorities are grossly underrepresented at all levels of postsecondary education, except for 2 year and vocational colleges. Enrollments of blacks in graduate school peaked in the academic year 1976 to 1977.

Because it is imperative that minorities' participation in higher education at the graduate level be promoted, USSA recommends investing $5 million in the graduate fellowship program for early identification, and also encourages Congress to increase funding beyond inflation adjustments for the other existing graduate assistance programs.

Regarding the Federal loan programs, USSA supports the Perkins loan program as a supplement to need-based grants. USSA recommends a $192 million appropriation for new Federal capital for the low-interest Perkins loans.

USSA opposes the administration's proposed expansion of the income contingent loan, ICL, program. It is unwise to expand this pilot program before we have data regarding its effects.

In addition, USSA objects to the ICL's because the interest lacks a fixed rate, and accrues during the period of enrollment.

PREPARED STATEMENT

Mr. Chairman, I will close by acknowledging that resources are scarce in fiscal year 1990. I would, however, like to remind you that increased education funding is an investment you cannot afford not to make.

The recommendations I have presented to you today are merely the first step in achieving adequate funding for education.

Thank you for the opportunity to present the views of the U.S. Student Association to the subcommittee.

Senator BURDICK. Thank you for your contribution.

Ms. LIEBERMAN. Thank you.

[The statement follows:]

STATEMENT OF JANET LIEBERMAN

Mr. Chairman and members of the Subcommittee, I am Janet Lieberman, Legislative Director of the United States Student Association (USSA). USSA is a national membership organization representing students attending diverse colleges and universities around the country. Our primary goals are to increase access to postsecondary education and to improve educational opportunity for all individuals in our nation. I am very pleased to appear before you to present USSA's recommendations for higher education appropriations in fiscal year 1990. Before I begin, I would like to note that USSA endorses the testimony submitted before you by the National Coalition for Women and Girls in Education, of which I am the Legislative Co-Chair.

PELL GRANTS

Pell Grants are the cornerstone of the federal financial aid programs, providing about three million students with grant assistance. An estimated 82 percent of Pell Grant appropriations go to students with adjusted family incomes of $15,000/year or less. Nearly one half of Pell funds assist those with family incomes of $6,000/year or less. Fewer than 8 percent of the funds benefit students from families earning over $20,000/year.

USSA strongly supports fully funding Pell Grants with an increase in the maximum grant to $2,500 in FY 90. The purchasing power of the maximum Pell Grant has dropped by 30 percent since 1980, when inflation and increased college costs are taken into account. Retaining the FY 89 maximum of $2300 in FY 90 means reducing its purchasing power from 28 percent to an estimated 26 percent of average college costs. By increasing the maximum grant to $2500, you will be taking a small but important step toward restoring Pell Grant funding to an appropriate level. USSA also urges you to fund the Pell Grant program fully to allow newly eligible less-than-half-time-students to receive aid without a reduction in aid to full- and half-time students. USSA recommends investing $5.114 billion in Pell Grants for FY 90.

TRIO PROGRAMS

TRIO Programs, Special Programs for Disadvantaged Students, are the most effective federally funded retention programs. Serving low-income, first generation to attend college, and physically challenged students, TRIO programs reach disadvantaged high-school aged and adult students by providing the information, counselling, tutoring, and role models needed to get individuals interested in, prepared for, and able to apply to college and to remain in school.

USSA commends Congress for appropriating FY 89 funds for the recently authorized program, Ronald E. McNair post-baccalaureate achievement scholarships. An appropriation of $5 million for FY 90 would assist more low-income students in their efforts to receive doctorate degrees.

Last year's hearings on the Guaranteed Student Loan default issue illuminated the fact that a major contributing factor encouraging default on a loan is lack of educational success. TRIO programs do what no other federal aid programs can: help those most at risk of educational failure to achieve success in school.

The number of students served under TRIO has declined since 1980 as federal appropriations have failed to keep pace with program costs and inflation. TRIO must be funded at $265.5 million in FY90 to assure a 15 percent increase in the number of TRIO students served. USSA strongly encourages the Congress to invest this amount, which will result in assistance for approximately 577,000 students, still less than 10 percent of the eligible population, to enroll and succeed in postsecondary education.

CAMPUS-BASED PROGRAMS

College Work Study, Supplemental Educational Opportunity Grants (SEOG), and State Student Incentive Grants (SSIG) allow financial aid administrators the flexibility to assess individual need and to award relatively small amounts of aid to students needing additional financial assistance to enroll or remain in school. Unfortunately, from FY 80 to FY 89, when adjusting for inflation, we see that College Work Study funding declined 24 percent, SEOG declined 18 percent, and SSIG declined 46 percent. USSA supports appropriations increases for these important programs to keep pace with inflation and college costs and to begin to restore the funding which has eroded over the past eight years. Our recommendations are as follows: College Work Study, $666 million; SEOG, $478 million; and SSIG, $84 million.

TITLE IX

USSA supports funding for graduate assistance, particularly to encourage minority participation in graduate education (HEA IX-A). Racial minorities are grossly underrepresented at all levels of postsecondary education except for two year and vocational colleges, and the situation is not currently improving. Enrollment of Blacks in graduate school peaked in academic year 1976-77. If we fail to promote Blacks' and other racial minorities' participation in higher education at the graduate level, we will continue to have extremely poor representation of Black and other minority professors. USSA recommends an appropriation of $5 million to fund this important initiative in its third year. USSA also encourages Congress to increase funding beyond inflation adjustments for the other existing graduate assistance programs.

FEDERAL LOAN PROGRAMS

USSA supports the Perkins (formerly the National Direct Student Loan) program as a supplement to need-based grant programs and recommends the continuation of capital contributions into the program. Like the campus-based grant programs (SSIG, College Work Study, and SEOG), Perkins loans provide for flexibility on the part of the financial aid administrator to assess individual need and to deliver money to those students with exceptional need. USSA recommends a $192 million appropriation for new federal capital for the Perkins Loans.

USSA opposes the Administration's proposed expansion of the Income Contingent Loan (ICL) pilot program. ICL was authorized as a five year, ten institution demonstration project, with a feasibility study to be completed by October of 1991. It is unwise to expand this pilot program before we have data regarding its effects. In addition, because the ICL's interest lacks a fixed rate and accrues during the period of enrollment, it is highly objectionable to USSA. Borrowers with modest incomes will pay much more than those who immediately enter high-paying fields. In fact, some individuals might continue to pay interest for many years without ever reducing the principal on the loan. Increased funding for this problematic program would deplete the already inadequate resources channeled toward other need-based student financial aid programs.

Mr. Chairman, I will close by acknowledging that resources are scarce in FY 90, and that budgetary constraints will force you to decide just what we can afford. I would like to remind you, however, that increased education funding is an investment you cannot afford not to make. FY 90 is the first fiscal year of the final decade of the twentieth century. This subcommittee must act now if we are to be prepared to face the challenges of the twenty-first century. Adequate investment now in our nation's children, students, and schools will also increase our competitiveness and save us countless dollars which would otherwise be spent on welfare, crime prevention, jails, and subsidies for the undereducated and unemployable. The recommendations I have presented to you today are merely the first step in achieving adequate funding for education. Thank you for the opportunity to present the views of the United States Student Association to this subcommittee.

STATEMENT OF JULIE GOODMAN, EXECUTIVE DIRECTOR, ASSOCIATION OF WOMEN IN SCIENCE; SECRETARY, NATIONAL COALITION FOR WOMEN AND GIRLS IN EDUCATION

Senator **Burdick**. The next witness is Julie Goodman, executive director of the Association of Women in Science, National Coalition for Women and Girls in Education.

Ms. **Goodman**. Thank you, Mr. Chairman.

I am Julie Goodman, executive director of the Association for Women in Science and secretary of the National Coalition for Women and Girls in Education.

The coalition represents over 60 diverse women's education and civil rights organizations, committed to expanding equity for women and girls in all aspects of education.

Most recently, the coalition has worked with Congress on passage of the Civil Rights Restoration Act and the reauthorization of the Carl Perkins Vocational Education Act of 1984.

We are very pleased to give you our recommendations on funding for four specific areas: Student aid, the Office of Civil Rights, Women's Educational Equity Act, and vocational education, for fiscal year 1990.

The coalition urges you to fund college work-study at $666 million, Perkins loans at $224 million, State student incentive grants at $78 million, and supplemental educational opportunity grants at $478 million, which would provide for an inflation increase and make an added investment of 5 percent over fiscal year 1989 for these important student aid programs.

In addition, we urge you to fund Pell grants at $5.1 billion.

In the last 8 years, funding for education has not kept pace with inflation, despite an increase in the number of disadvantaged students, most in the education programs.

Fully 53 percent of all undergraduate students are now women, up from 46 percent only 15 years ago. Overall, women students have greater financial need and often depend on these student aid programs more than men students.

Women students are more likely than men students to be single parents, self-supporting, older than average, and from lower-income families.

In the Higher Education Amendments of 1986, Congress extended eligibility for Pell grants to students enrolled less than half time. This expansion particularly benefits women, who are more likely to be studying part time while they balance work and family responsibilities.

Full funding for the Pell grant program will ensure that newly eligible part-time students can get aid without reducing grants for full-time students.

The coalition also encourages you to begin to restore the purchasing power of Pell grants by funding an increase in the maximum grant from $2,300 to $2,500. It is imperative that we begin to reverse the trend toward increasing reliance on loans, rather than grants, in student aid packages.

The coalition also strongly supports appropriating $61.8 million for the Office of Civil Rights, which would restore funding to 1981 levels, adjusting for inflation.

OCR has the important responsibility of enforcing Federal laws which prohibit discrimination in education programs or activities funded by the Federal Government. This includes title IX of the Education Amendments of 1972, which prohibits sex discrimination in federally funded education programs and activities, and which is a key priority for the coalition.

Like other civil rights programs, OCR has suffered a radical reduction in funding over the past 8 years. It dropped from a budget of $46.9 million in fiscal year 1981 to only $40.8 million in fiscal year 1989.

Not surprisingly, this reduction in dollars has also resulted in a significant decrease in staff.

The result of these cuts has been a dramatic decrease in OCR's ability to investigate complaints, undertake compliance reviews, and otherwise carry out its mandate to eliminate federally funded discrimination.

The problem is all the more significant in that following the passage of the Civil Rights Restoration Act last year, OCR's broad jurisdiction was reestablished and the number of complaints and breadth of compliance reviews has increased dramatically.

Indeed, the number of complaints filed in 1988 was up over 78 percent from 1987, and we expect to see further increase in 1989. The result is that OCR has insufficient resources to do its job.

In order to bring OCR to a minimally acceptable level of functioning, we urge this committee to provide $61.7 million.

The coalition recommends a $6 million appropriation for the Women's Educational Equity Act, also known as WEEA, for fiscal year 1990.

WEEA was originally enacted in 1974 to remedy widespread sex discrimination in education. Since then, it has been reauthorized four times, most recently in 1988.

WEEA authorizes the Department of Education to award grants and contracts to nonprofit organizations and educational agencies to develop, demonstrate, and disseminate educational equity products and programs.

WEEA is extremely cost-effective because models developed can be replicated across the Nation. It is the only Federal program with a comprehensive mandate to fund projects on sex equity at all levels of education for all aspects of education, including administration, athletics, counseling and curriculum reform, and for both minority and disabled women and girls.

Although WEEA has been on the books for 15 years, new issues are constantly emerging. WEEA pioneered projects focused on increasing access for women and girls to mathematics and science and computer education long before these problems were seen as national priorities.

Today, many WEEA projects deal with female dropouts and teen pregnancy prevention.

Over the past 9 years, WEEA funding has been slashed 71 percent. Currently, funds stand at $2.9 million, a far cry from the $10 million appropriated for WEEA in 1980. As a result of these cuts, only 28 projects were funded nationwide in 1989 of 201 applications.

The coalition has commented on proposed regulations promulgated by the Department of Education for the WEEA program. We would urge this committee to require that funds appropriated for fiscal year 1990 be spent according to existing regulations, so that WEEA's historical purpose can continue.

We recommend that Congress take a positive step this year and restore a portion of WEEA funds by appropriating $6 million in 1990. WEEA and the girls and women it serves cannot afford further cuts.

The coalition also recommends $1 billion in funding for vocational education for fiscal year 1990, which would provide for an inflation adjustment and an added investment of 5 percent over fiscal year 1989.

This increase would directly impact the two set-asides that provide needed vocational educational services for women and girls, the 8.5 percent set-aside for single parents and homemakers, and the 3.5 percent set-aside for sex equity programs.

The increase is necessary just to keep pace with inflation. The single parent and homemaker and the sex equity set-asides are good examples of why this is a good investment. The Perkins Act provides the largest commitment of Federal dollars for educating women and girls in the Nation's history. And that commitment has netted results.

Nationwide, sex equity funds have been successful in establishing programs to battle sex stereotyping—I am going to try to cut this a little short.

Most new entrants into the work force in the decades to come will be women, minorities, and immigrants. A majority of these people will rely on vocational education or on-the-job training for their labor market skills.

PREPARED STATEMENT

Funding of $1 billion for vocational education will translate into approximately $120 million for States to use to serve their women and girls who will fill the jobs of the future.

The coalition urges you to appropriate $1 billion as a minimum investment in vocational education. Thank you very much.

Senator BURDICK. Thank you.

[The statement follows:]

STATEMENT OF JULIE GOODMAN

Good morning. I am Julie Goodman, Executive Director of the Association of Women in Science, Secretary of the National Coalition for Women and Girls in Education. The coalition represents over 60 diverse women's, education, and civil rights organizations committed to expanding equity for women and girls in all aspects of education. Most recently, the coalition has worked with Congress on passage of the Civil Rights Restoration Act, and the reauthorization of the Carl D. Perkins Vocational Education Act of 1984. We are very pleased to give you our recommendations on funding for student aid, the Office of Civil Rights, Women's Educational Equity Act, and vocational education for fiscal year 1990.

The coalition urges you to fund College Work Study at $666 million, Perkins Loans at $224 million, State Student Incentive Grants at $78 million, and Supplemental Education Opportunity Grants at $478 million, which would provide for an inflation increase, and make an added investment of 5% over FY 1989, for these important student aid programs. In addition, we urge you to fund Pell Grants at $5.1 billion. In the last eight years, funding for education has not kept pace with inflation, despite an increase in the number of disadvantaged students most in need of education programs. Fully 53% of all undergraduate students are now women, up from 46% only 15 years ago. Overall, women students have greater financial need--and often depend on these student aid programs more--than men students. Women students are more likely than men students to be single parents, self-supporting, older than average, and from lower-income families.

In the Higher Education Amendments of 1986, Congress extended eligibility for Pell Grants to students enrolled less than half-time. This expansion particularly benefits women, who are more likely to be studying part time while they balance work and family responsibilities. Full funding for the Pell Grant program will ensure that newly eligible part-time students can get aid without reducing grants for full-time students. The coalition also encourages you to begin to restore the purchasing power of Pell Grants by funding an increase in the maximum grant from $2,300 to $2,500. Increases beyond inflation for Pell Grants, Supplemental Educational Opportunity Grants and State Student Incentive Grants are all needed to begin to reverse the trend towards increasing reliance on loans rather than grants in student aid packages.

The coalition also strongly supports appropriating $61.8 million for the Office for Civil Rights (OCR), which would restore funding to 1981 levels, adjusting for inflation. OCR has the important responsibility of enforcing federal laws which prohibit discrimination in education programs or activities funded by the federal government. This includes Title IX of the Education Amendments of 1972 which prohibits sex discrimination in federally funded education programs and activities and which is a key priority for the coalition.

Like other civil rights programs, OCR has suffered a radical reduction in funding over the past eight years. It dropped from a budget of $46.9 million in FY 1981 to only $40.8 million in FY 1989. Not surprisingly, this reduction in dollars has also resulted in a significant decrease in staff, dropping from 1099 full time staff positions in FY 1981 to a current ceiling--which has not been reached--of only 820 full time positions.

The result of these cuts has been a dramatic decrease in OCR's ability to investigate complaints, undertake compliance reviews and otherwise carry out its mandate to eliminate federally funded discrimination. The problem is all the more significant in that following the passage of the Civil Rights Restoration Act last year, OCR's broad jurisdiction was reestablished and the number of complaints and breadth of compliance reviews has increased dramatically. Indeed, the number of complaints filed in 1988 was up over 78% from 1987 and we expect to see further increases in 1989. The result is that OCR has insufficient resources to do its job. In order to bring OCR to a minimally acceptable level of functioning, we urge this Committee to provide $61.7 million.

The coalition recommends a $6 million appropriation for the Women's Education Equity Act (WEEA) for the FY 1990. WEEA was originally enacted in 1974 to remedy widespread sex discrimination in education. Since then it has been reauthorized four times, most recently in 1988. WEEA authorizes the Department of Education to award grants and contracts to non-profit organizations and educational agencies to develop, demonstrate and disseminate educational equity products and programs. WEEA is extremely cost-effective because models developed can be replicated across the nation. It is the only federal program with a comprehensive mandate to fund projects on sex equity at all levels of education, for all aspects of education--including administration, athletics, counseling, and curriculum reform--and for both minority and disabled women and girls.

Although WEEA has been on the books for 15 years, new issues are constantly emerging. WEEA pioneered projects focused on increasing access for women and girls to mathematics, and science and computer education, long before these problems were seen as national priorities. Today, many WEEA projects deal with female dropouts and teen pregnancy prevention.

Over the past nine years, WEEA funding has been slashed 71 percent. Current WEEA funds stand at $2.9 million, a far cry from the $10 million appropriated for WEEA in 1980. As a result of these cuts, only 28 projects were funded nationwide in 1989 of 201 applications. Under current law, funding above $4.5 million can be applied to direct implementation of programs developed with WEEA funds. The coalition has commented on proposed regulations promulgated by the Department of Education for the WEEA program; we would urge this committee to require that funds appropriated for FY 1990 be spent according to existing regulations so that WEEA's historical purpose can continue. We recommend that Congress take a positive step this year and restore a portion of WEEA funds by appropriating $6 million in 1990. WEEA, and the girls and women it serves, cannot afford further cuts.

The coalition recommends $1 billion in funding for vocational education for FY 1990, which would provide for an inflation adjustment, and an added investment of 5%, over fiscal year 1989. This increase would directly impact the two set-asides that provide needed vocational education services for women and girls: the 8.5% set-aside for single parents and homemakers, and the 3.5% set-aside for sex equity programs. The increase is necessary just to keep pace with inflation. The single parent and homemaker and the sex equity set-asides are good examples of why this is a good investment. The Perkins Act provides the largest commitment of federal dollars for educating women and girls in the nation's history, and that commitment has netted results. Nationwide, sex equity funds have been successful in establishing programs to battle sex stereotyping; of the 50 states, 26 provide teacher training, 25 provide outreach, 16 provide direct services to individuals or school districts, 11 provide curriculum development, 11 provide counseling and development, and 4 fund research. The number of programs for displaced homemakers has risen from 435 in 1984 to nearly 1000 in 1987.

Most new entrants into the workforce in the decades to come will be women, minorities and immigrants. A majority of these people will rely on vocational education or on-the-job training for their labor market skills. Funding of $1 billion for vocational education will translate into approximately $120 million for states to use to serve the women and girls who will fill the jobs of the future. The coalition urges you to appropriate $1 billion as a minimum investment in vocational education.

Thank you very much.

STATEMENT OF TERRENCE R. DOLAN, PROFESSOR, UNIVERSITY OF WISCONSIN-MADISON; PRESIDENT, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR PERSONS WITH DISABILITIES

Senator BURDICK. Our next witness is Terrence R. Dolan, University of Wisconsin, Madison, American Association of University Affiliated Programs for Persons with Disabilities.

Mr. DOLAN. Thank you, Senator Burdick.

I am Terrence Dolan. I am a professor at the University of Wisconsin at Madison, and director of a mental retardation research center.

I am here today as president of the American Association of University Affiliated Programs.

Senator BURDICK. What is this university in Madison business?

Mr. DOLAN. I said, University of Wisconsin at Madison, did I not?

Senator BURDICK. It is still the University of Wisconsin?

Mr. DOLAN. Oh, it is. Did I not say University of Wisconsin at Madison?

There are 26 campuses. I am on the campus that is in Madison.

Senator BURDICK. Have you got a football field?

Mr. **Dolan**. We actually do not need a football field anymore—we do not have a football team to play on it.

Senator **Burdick**. You were not too good when I was there.

Mr. **Dolan**. They were what?

Senator **Burdick**. I am a Minnesota man.

Mr. **Dolan**. Maybe I should put this testimony away, and we should talk about football. [Laughter.]

Senator **Burdick**. Proceed.

Mr. **Dolan**. I wanted to say, first of all, thank you to this subcommittee on behalf of persons with mental retardation and developmental disabilities for their efforts in the past years. It is a great honor for me to say that this is the fifth year that I have provided testimony on behalf of persons with developmental disabilities.

I have already submitted written testimony. I can be very brief.

I would like simply to make two points. The first has to do with the budget of the Administration on Developmental Disabilities. The Administration on Developmental Disabilities supports a network of clinical service and training programs called the University Affiliated Programs.

Last year, the UAP's provided comprehensive services to 75,000 persons with developmental disabilities. They provided training to 7,000 post-baccalaureate trainees that were entering into fields to work with persons with disabilities, and they provided on-the-job training, in-service training, to approximately 190,000 persons in this country who work with persons with developmental disabilities.

The point I want to make is that not a one of those persons with disabilities, not one of those students, not one of those on-the-job workers, resides in the States of Alaska, or Delaware, or Maine, or New Hampshire, or New Mexico, or Nevada, North Dakota, Oklahoma, or Rhode Island.

The reason is that the budget of the ADD has not yet allowed the expansion of the UAP network to move into those States. As a consequence, those States still do not have the benefits of UAP programs that other States do.

So the first request that I would make is that this committee strongly consider increasing the budget of the ADD by $2 million next year, in order for them to continue the expansion that they started this year, and move into four additional States.

The second point I wanted to make has to do with support of research on mental retardation and developmental disabilities. At the NIH, the Institute responsible for research on MR and DD, is the National Institute of Child Health and Human Development.

I am sure this committee has already heard from other people providing testimony about the plight of the NICHD. It is now at the bottom of the seven major institutes at the NIH. The award rate of that Institute this year will be the lowest in the history of the Institute with the budget proposed by the administration—approximately 19 percent of all approved grants.

When John Kennedy was president, legislation was enacted to create the network of MR research centers. There are now 12 in the country. That number has been frozen at 12 for 25 years, and the resources now available to those research centers is just under one-half of what it was in 1974, in constant dollars.

PREPARED STATEMENT

We would urge this committee to consider increasing the budget of the NICHD mental retardation research line, to allow the Institute to allow the first expansion of the network in 25 years, and to reduce the cuts in the budgets of the centers that they are now sustaining.

This year, the cuts in those budgets will be approximately 17 percent, again, given the request from the administration.

So it is just those two issues that I would like to highlight, and I appreciate the opportunity to appear here today.

Senator BURDICK. Thank you.

[The statement follows:]

STATEMENT OF TERRENCE R. DOLAN

I am Dr. Terrence Dolan, Director of the Waisman Center on Mental Retardation and Human Development, a research, clinical service, and training center at the University of Wisconsin-Madison. I am also this year's president of the American Association of University Affiliated Programs for Persons with Developmental Disabilities (AAUAP).

My primary purpose in being here today is to emphasize the importance of adequate and appropriate resources for training personnel who provide services to persons with developmental disabilities, and resources to conduct research that contributes new knowledge to the prevention and treatment of developmental disabilities. In particular, I wish to address you concerning three important issues:

1. the budget of the Administration on Developmental Disabilities and its support of University Affiliated Programs (UAPs) throughout the nation;

2. the budget of the Division of Maternal and Child Health and the 15 per cent set-aside of its budget for training programs; and

3. the budget of the National Institute of Child Health and Human Development and its support of mental retardation research centers.

DEVELOPMENTAL DISABILITIES ACT

The first issue concerns the Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1987 that passed two years ago. In that legislation, the Congress authorized the Administration of Developmental Disabilities to support significant new training initiatives for the 56 federally funded University Affiliated Programs known as UAPs that are distributed throughout 38 states in our nation. (To remind you, the UAPs are a national network of service and training centers that serve persons with developmental disabilities. Last year the UAPs provided interdisciplinary services to 75,000 persons with developmental disabilities; they provided interdisciplinary training programs to 7,000 trainees; and they provided in-service and outreach training programs to 190,000 health, social, and education professionals.) The new training initiatives were designed to provide training in three vital areas: 1) training to direct-care workers, 2) training to early intervention providers, and 3) training to persons who care for aged persons with developmental disabilities.

Regarding the training of direct-care workers, the DD Act has historically embodied Congress' commitment to insuring that persons with developmental disabilities receive the care, treatment, and other services necessary to make community living a reality. Consequently, it is not surprising that the authorization committees in both houses recognized the need to train the workers who have the most day-to-day contact with handicapped persons -- paraprofessionals. These individuals, including case-workers, psychiatric technicians, rehabilitation assistants, house parents, job coaches and group home workers, constitute the foundation of the community-based residential services system. The new DD Act attempts to tackle the enormous challenge of providing these workers with basic training and badly needed skills. And make no mistake, the task is staggering. Recent estimates indicate that the present demand for paraprofessionals to perform basic services in small, community residential settings is 50,000 nationwide. By the year 2000, that estimate jumps to over 75,000 hands-on staff necessary to perform essential daily tasks. AAUAP believes that the paraprofessional training initiative is the first step in a broader effort involving other federally funded programs, state agencies, local entities, and community and junior colleges to provide high quality services in less restrictive, better integrated residential environments.

The second area addressed by the new developmental disabilities legislation is the provision of early intervention services. In 1986 Congress, under the Education of the Handicapped Act, created a new early intervention program to assist states in implementing a state-wide, multidisciplinary, and interagency program of early intervention services to handicapped infants and toddlers from birth through two years of age. The program mandates the provision of family training and counseling, care coordination services, physical and occupational therapy, psychological services, and early identification, screening, and assessment services. The substantive value of these activities cannot be reasonably disputed since numerous studies have demonstrated that early intervention strengthens prevention, facilitates future community integration, and actually reduces the severity of a child's functional limitations.

However, on a national basis, we lack the qualified allied health professionals needed to competently administer the mandated services. For example, a recent survey of the 50 states reveals that 96.2% report substantial shortages of trained physical therapists, speech-language pathologists, and occupational therapists to work in early intervention programs. In addition, 82.7% of the states expect the shortage to continue through 1991, the first year of implementation of the birth through two program under EHA. Moreover, these personnel projections come at a time when the Office of Special Eduction Programs estimates that, based on current state eligibility definitions, 100,000 disabled infants and toddlers will be eligible for early intervention services. The new DD Act provides UAPs with the specific charge to train the needed allied health and related professionals necessary to do the job right.

Finally, Congress addressed the specialized personnel preparation needs of the burgeoning population of elderly persons with developmental disabilities. The national statistics in this area are truly alarming. Using 1986 data, there are currently 200,000 people over age fifty-five (55) with a developmental delay or disability. This population is projected to increase to 589,000 by the year 2020. Indeed, these statistics would imply that, as we approach the 21st century, about 4 out of every 1000 older Americans will face a handicapping condition. The new legislation begins to address the training implications of these numbers by authorizing cooperative programs between UAPs and university-based gerontological training programs across the country.

Chairman Natcher and members of the subcommittee, your strong leadership in fighting for the passage of the DD Act Amendments of 1987 permitted these special training initiatives to be developed. I want to take this opportunity to thank you and express the appreciation of my entire national association for your continuing advocacy in improving both the quantity and quality of services to persons with developmental disabilities.

In view of the UAP network's commitment to persons with developmental disabilities, and the significance of their efforts in their respective states, we strongly believe that the investment Congress has made in personnel preparation through the Developmental Disabilities Act and other UAP activities will have a significant national impact. However, there still are 15 states and territories that do not yet have a UAP. Those states simply do not have an identified, federally funded, and mandated UAP program to carry out the activities conducted in states that do have UAPs. On behalf of those states, which include Alaska, Delaware, Maine, New Hampshire, New Mexico, Nevada, North Dakota, Oklahoma, Rhode Island, Texas, Wyoming, and Pacific and Caribbean territories, we seek additional support for the development of programs in these states.

Hence, the AAUAP proposes an additional $2 million for the DD-UAP system -- still well below the authorization ceiling for the program -- to:

a.) further expand the network into four unserved states per year as mandated by the Developmental Disabilities Act, and

b.) provide enhanced support for the three training initiatives I described above.

MATERNAL AND CHILD HEALTH BLOCK GRANT

In another critical area, a variety of proposals has been put forth concerning enhancing federal support for Title V of the Social Security Act, otherwise known as the Maternal and Child Health Block Grant. In fact, Congressman Henry Waxman, chairman of the House Health and Environment Subcommittee, has proposed a $100 million increase for the program in FY 1990. The president has recommended that it be frozen at its present overall funding level of $554 million.

Mr. Chairman, the Maternal and Child Health Block Grant is our Nation's frontline defense against infant mortality and morbidity. The program is designed to provide primary and perinatal care to low income mothers and children and specialized services to youngsters with chronic illness and disabling conditions. As you know, access to health care is often very difficult in core inner cities and rural areas like your home state of Iowa, primarily due to lack of provider availability. It seems clear that the disgraceful U.S. infant mortality rate -- we now rank 19th among the world's industrialized nations-- is due at least in part to the devastating funding reductions that this program sustained in 1981.

Many of the bills introduced to date contain exciting new proposals including a home visit program, one-stop shopping services, and extensive care coordination for children with special health care needs. Whatever final piece of legislation results from these various recommendations, we hope that sufficient federal and state resources -- in line with Chairman Waxman's request -- will be available to dramatically reduce the current infant mortality rate. Moreover, AAUAP believes that the 15% federal set-aside, which supports Special Projects of Regional and National Significance, should be maintained and accounted for in all future Title V increases. These programs, which include our own UAP programs, Pediatric Pulmonary Centers, and many others, provide training and exemplary services to children with disabilities ranging from cerebral palsy to cystic fibrosis.

MENTAL RETARDATION RESEARCH CENTERS

Finally, Mr. Chairman, I would like to conclude my testimony with a brief discussion of the fiscal plight now facing the National Institute of Child Health and Human Development (NICHD), including its support of the nation's Mental Retardation Research Centers (MRRCs). It is now clear that our national effort to prevent mental retardation and developmental disabilities is being undermined by consistently inadequate financial support. The Administration has proposed an NICHD budget for next year of $444,193,000, including $27,129,000 specifically for AIDS research. Under this FY 1990 proposed budget the funding rate for grants at NICHD would be 19.7 per cent (compared to 25.3 per cent in FY 1989). This would be the lowest funding rate in the history of the Institute.

Further, the record reveals that the MRRC national network --the only federally supported research program of its kind in the country-- has not been adequately funded for many years. For example, when discounted for inflation, resources available to the NICHD Mental Retardation and Developmental Disabilities Branch in general, and the MRRCs in particular, are less than one-half of what they were in 1975.

More recently, funding for these research centers has experienced so-called "negotiated reductions," which is an administrative procedure whereby core grant awards are cut -- by arbitrary across-the-board percentages-- below funding levels recommended by respected scientific peer review panels. For the last three consecutive fiscal years, these reductions have averaged close to 15%. With the President proposing $444 million for all of NICHD in FY 1990, the agency has projected that the MRRCs will sustain another cut of over 17%.

These continuing fiscal assaults come despite the fact that the MRRC national network has contributed substantially to the actual prevention of mental retardation. Current biomedical research is providing critical, new information about the genetic mechanisms responsible for whole classes of developmental disabilities that may be eliminated as the result of these research efforts. In addition, behavioral scientists are making significant new contributions concerning early intervention and the amelioration of limitations that previously prevented persons with developmental disabilities from living and working in their home settings.

In response to this proposed further deterioration in support of the NICHD and the MRRCs, we urge you to:

1. increase funding to the NICHD to $584,632,000 in FY 1990 instead of the President's proposed $444,193,000. This "best professional judgment" budget would allow full NICHD funding of 537 competing research project grants at a cost of $113,773,000, a funding rate of 30 per cent (comparable to other NIH institutes);

2. obligate an additional $12 million for the research center line-item of the NICHD budget. With these added resources, the Director of the NICHD has proposed:

a.) the creation of three new MRRCs, which would represent the first expansion for the program in more than 20 years. Such states as Minnesota, New York, Iowa, Florida, and Alabama have already expressed interest in developing mental retardation research centers and are ready to more forward when these needed resources are available; and

b.) the entire elimination of the projected negotiated reductions for FY 1990 for all NICHD-funded research centers. These include centers in population biology, in reproductive sciences and other areas of great importance in our national effort to understand and eliminate disease.

Thank you for taking time out of your busy schedule to listen to me today.

SUMMARY OF REQUESTS

Administration on Developmental Disabilities:

Increase the ADD budget by $2,000,000 to:
1. expand national network of UAPs to four new states; and
2. provide additional support for training initiatives in states where they do not presently exist.

Division of Maternal and Child Health:

Maintain the 15 per cent federal set-aside for present and future Title V increases to support the Special Projects of Regional and National Significance as well as the training activities of the UAPs and other specialized training programs.

National Institute for Child Health and Human Development:

1. Increase NICHD budget to $584,632,000 to achieve comparability with other NIH institutes;

2. Increase the NICHD Research Center Line by $12,000,000 to allow expansion of mental retardation research centers network to three new states, to create one new learning disabilities center, and to eliminate significant reductions to all current NICHD-supported centers.

STATEMENT OF MAX LARSEN, NEBRASKA STATE BOARD OF EDUCATION

Senator **Burdick**. Next, Max Larsen, Nebraska State Board of Education.

Mr. **Larsen**. Thank you, Senator Burdick.

My name is Max Larsen. I am a member of the Nebraska State Board of Education, and I am chairman of the governmental affairs committee of the National Association of State Boards of Education.

I am pleased to be here to testify on behalf of State board members all across the country.

Very little can be said that has not already been articulated over the past several years about the need for a strong partnership between the Federal Government and States and localities in funding education.

The time has come to enhance and expand that partnership. I want to emphasize three recommendations that are included in the written testimony. First of all, NASBE recommends a continued funding priority for chapter I which meets the needs of disadvantaged children.

We join NASBA that testified earlier in that same recommendation.

We also recommend continued funding for chapter II. Chapter II funds provide innovation that helped make our schools and our Nation competitive. You heard today about gifted programs being funded from that. There are programs in Des Moines, IA, and Omaha, NE, where chapter II funds are used to provide chapter I-like services to kids who do not qualify.

Your subcommittee will be faced with competition between education funds and basic services for children. We feel it is a mistake to sacrifice one for the other, and urge you not to sacrifice education for basic services or vice versa.

Hungry children, abused children, and children without homes find it hard to read, write, and to count. We feel that Congress must make a commitment to the whole child in 1990.

A part of this comprehensive approach includes funding for the authorization for Early Childhood Initiative. Earlier today we had touching testimony by Rachel and Eric, because their disabilities are very obvious, and it is clear that some funding can help make an improvement.

But there are 30 million kids in this country right now that are born with another disability that is not quite so obvious—they were born poor. And unless early childhood education programs can make a difference, that cycle of poverty, that disability they have, cannot be broken.

We know now what we have to do to break that cycle of poverty, and we ask you to help fund some of those programs. Effective early childhood education programs prevent failure. Preventing failure costs a lot less than trying remedial programs that come later.

We also know that Head Start makes a big difference in the eventual success of kids. But right now, fewer than 20 percent of the eligible children are receiving those services because the program is inadequately funded.

PREPARED STATEMENT

Safe, high-quality early childhood education and child care are imperative to the well-being of our children.

State boards of education concern has traditionally been K–12, but we know that unless we improve services in early childhood education, our programs cannot reach their full success.

We urge you to choose in favor of our Nation's children as you deal with the competing budget requests that you have.

Thank you for this opportunity. Are there any questions at this time?

Senator BURDICK. Thank you, Mr. Larsen.

[The statement follows:]

STATEMENT OF MAX LARSEN

CHAIRMAN HARKIN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE: MY NAME IS MAX LARSEN. I AM A MEMBER OF THE NEBRASKA STATE BOARD OF EDUCATION AND I AM THE CHAIRMAN OF THE GOVERNMENTAL AFFAIRS COMMITTEE OF THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION (NASBE). I AM VERY PLEASED TO HAVE THE OPPORTUNITY TO TESTIFY THIS MORNING ON BEHALF OF STATE BOARD MEMBERS ACROSS THE COUNTRY.

MR. CHAIRMAN, VERY LITTLE CAN BE SAID THAT HAS NOT BEEN ARTICULATED OVER THE LAST SEVERAL YEARS ON THE NEED FOR A STRONG FEDERAL PARTNERSHIP WITH STATES AND LOCALITIES IN FUNDING EDUCATION. THE TIME HAS COME TO ENHANCE AND EXPAND THAT PARTNERSHIP. IN ADDITION TO CONTINUED SUPPORT OF SUCH ESSENTIAL FEDERAL EDUCATION PROGRAMS AS CHAPTER 1, EDUCATION FOR HANDICAPPED STUDENTS AND CHAPTER 2, WHICH FUNDS FEDERAL, STATE, AND LOCAL PARTNERSHIPS FOR EDUCATIONAL IMPROVEMENT, WE URGE CONGRESS TO PASS AND FUND A COMPREHENSIVE PACKAGE FOR EARLY CHILDHOOD EDUCATION AND CHILD CARE .

THE EFFECTIVENESS OF CHAPTER 1 IS WELL-DOCUMENTED. STUDIES AT THE FEDERAL, STATE AND LOCAL LEVELS SHOW THAT LOW-ACHIEVING CHILDREN WHO PARTICIPATE IN CHAPTER 1 DO SIGNIFICANTLY BETTER ACADEMICALLY THAN SIMILAR CHILDREN WHO DO NOT PARTICIPATE.

CHAPTER 2 PROVIDES STATES WITH A CONTINUING SOURCE OF FUNDS FOR INNOVATION, AND EDUCATIONAL IMPROVEMENT. IN STATES WITH LIMITED RESOURCES, IT HAS FUELED EDUCATION REFORM AND SUPPORTED THE KINDS OF PROGRAMS CONGRESS HAS IDENTIFIED AS NECESSARY TO MAKE SCHOOLS AND THE NATION COMPETITIVE. IT'S FOCUS IS QUALITY, YET MANY STATES ALSO USE THE FUNDS TO FURTHER ADVANCE EQUITY AS WELL. FEW PEOPLE REALLY KNOW HOW MUCH IT HELPS STATES MEET THE SPECIAL EDUCATION NEEDS OF AT-RISK STUDENTS.

FOR EXAMPLE, THE DES MOINES, IOWA SCHOOL DISTRICT CURRENTLY USES CHAPTER 2 FUNDING TO PROVIDE SPECIAL ELEMENTARY READING, WRITING AND MATH PROGRAMS FOR STUDENTS WHO OTHERWISE WOULD BE ELIGIBLE FOR THE CHAPTER 1 PROGRAM, BUT ARE NOT BECAUSE OF INSUFFICIENT DENSITY OF DISADVANTAGED CHILDREN IN THE DES MOINES SCHOOL DISTRICT AS REQUIRED BY CHAPTER 1. THESE STUDENTS ARE PROVIDED ASSISTANCE THROUGH CHAPTER 2 FUNDING IN THE FORM OF SPECIALIZED, SMALL-GROUP, COMPUTER-ASSISTED INSTRUCTION. THE GOALS OF THE PROGRAM ARE TO HELP STUDENTS BE SUCCESSFUL AT AN EARLY AGE; TO IMPROVE STUDENTS' SELF-CONCEPTS; TO REDUCE THE NUMBER OF RETENTIONS AND DROPOUTS; AND TO GRADUATE STUDENTS FROM THE 8TH GRADE WHO HAVE ACHIEVED AT LEAST 8TH GRADE LEVEL COMPETENCY IN READING, WRITING AND MATH.

IN NEBRASKA, THE OMAHA PUBLIC SCHOOL SYSTEM IS USING CHAPTER 2 FUNDS TO SUPPORT EDUCATION PROGRAMS ASSISTING AT-RISK STUDENTS. MANY OF THESE STUDENTS NO LONGER HAVE ACCESS TO CHAPTER 1 SERVICES AS A RESULT OF A COURT-ORDERED DESEGREGATION PLAN WHICH SHIFTED THE CHAPTER 1 ELIGIBILITY OF THEIR SCHOOL. IN RESPONSE, THE OMAHA SCHOOL SYSTEM HAS BEGUN TO USE CHAPTER 2 MONEY TO CONTINUE SPECIAL SERVICES FOR THESE CHILDREN.

IN F.Y. 1988, CONGRESS APPROPRIATED $478 MILLION FOR THE CHAPTER 2 BASIC STATE GRANT. LAST YEAR THE HOUSE APPROPRIATED $489.5 MILLION FOR THE CHAPTER 2 BASIC STATE GRANT. UNFORTUNATELY, THE FINAL FISCAL YEAR 1989 APPROPRIATION LEVEL FOR THE BASIC STATE GRANT WAS $463 MILLION. THIS YEAR THE ADMINISTRATION HAS REQUESTED $478 MILLION WHICH WOULD RESTORE THE PROGRAM TO ITS FISCAL YEAR 1988 LEVEL. WE URGE YOU TO FUND THE CHAPTER 2 BASIC STATE GRANT AT THE FISCAL YEAR 1989 HOUSE LEVEL OF $489.5 MILLION PLUS INFLATION.

ALTHOUGH EDUCATION PROGRAMS ARE ESSENTIAL TO THE GROWTH AND DEVELOPMENT OF OUR CHILDREN AND TO THE WELL-BEING OF OUR SOCIETY, WE DON'T BELIEVE

IT IS WISE TO CHOOSE BETWEEN FUNDING PROGRAMS THAT EDUCATE OUR CHILDREN AND THOSE WHICH PROVIDE OUR CHILDREN WITH BASIC SERVICES AND ADDRESS THEIR SPECIAL NEEDS.

OUR GOVERNMENT COULD PROVIDE THE BEST EDUCATION PROGRAMS IN THE WORLD TO OUR YOUNG PEOPLE AND IT WON'T MAKE A DIFFERENCE IF OUR CHILDREN ARE HUNGRY, SICK ABUSED OR FRIGHTENED. OUR BEST TEACHERS ARE INEFFECTIVE IF THE BASIC NEEDS OF THE CHILDREN THEY'RE TRYING TO TEACH ARE NOT BEING MET OR IF THE SPECIAL PROBLEMS CONFRONTING OUR YOUTH ARE UNADDRESSED. CONSIDER THE UNPRECEDENTED PROBLEMS YOUNG PEOPLE FACE TODAY.

O ILLEGAL DRUG USE IS WIDESPREAD AMONG STUDENTS:

-FIFTY-SEVEN PERCENT OF HIGH SCHOOL SENIORS TRIED SOME ILLEGAL DRUG AND MORE THAN A THIRD HAVE TRIED AN ILLEGAL DRUG OTHER THAN MARIJUANA;

-TWENTY-ONE PERCENT OF SENIORS REPORTED SOME REGULAR MARIJUANA USE IN THE PAST MONTH AND ABOUT ONE IS SIX 13-YR OLDS HAS USED IT;

-ALTHOUGH THERE HAS BEEN A DROP IN STUDENT USE OF COCAINE, ABOUT ONE IN EVERY SIX HIGH SCHOOL STUDENTS HAS TRIED IT.

O NINETY-TWO PERCENT OF HIGH SCHOOL SENIORS HAVE TRIED ALCOHOL; 66.4 PERCENT ARE REGULAR USERS, APPROXIMATELY FIVE PERCENT DRINK DAILY, AND 37.5 PERCENT REPORT ONE EPISODE OF HEAVY DRINKING IN THE PRECEDING TWO WEEKS (FIVE OR MORE DRINKS)

O IN 1985, AN ESTIMATED 1 MILLION TEENAGERS (ONE IN TEN) BECAME PREGNANT WITH LESS THAN HALF RESULTING IN BIRTHS, AND ESTIMATED 40 PERCENT ENDING IN ABORTION, AND AN ESTIMATED 13 PERCENT ENDING IN MISCARRIAGE. LESS THAN HALF OF MOTHERS UNDER THE AGE OF 16 GET PRENATAL CARE, AND THEIR BABIES HAVE HIGH RATES OF DEATH AND DISABILITY IN COMPARISON WITH ALL BIRTHS.

O TWENTY-FOUR PERCENT OF ALL FATALITIES AND 41% OF ALL SERIOUS INJURIES IN REPORTED CASES OF PHYSICAL ABUSE INVOLVE PERSONS AGED 12 TO 17.

O SIX PERCENT OF ALL BOYS AND 15% OF GIRLS EXPERIENCE SEXUAL ABUSE BY THE AGE OF 16.

O SIX HUNDRED THOUSAND TEENAGE GIRLS AND THREE HUNDRED THOUSAND BOYS WORK AS PROSTITUTES; THEIR AVERAGE AGE IS 15.

O FIVE THOUSAND PERSONS UNDER THE AGE OF 19 COMMIT SUICIDE EACH YEAR, AND 50,000 ATTEMPT IT.

O UP TO TEN PERCENT OF TEEN AGE GIRLS SUFFER SEVERE EATING DISORDERS SUCH AS ANOREXIA.

- ONE IN 5 PEOPLE WITH AIDS IS IN HIS OR HER TWENTIES, WHICH MEANS THAT MANY WERE INFECTED WITH HIV WHILE STILL IN THEIR TEENS.

THE SPECIAL INDIVIDUAL NEEDS AND PROBLEMS OF OUR CHILDREN, TOGETHER WITH THEIR EDUCATIONAL NEEDS ALL MUST BE APPROACHED IN A COMPREHENSIVE FASHION. AS PART OF THIS COMPREHENSIVE APPROACH, SPECIAL ATTENTION SHOULD BE PAID TO PREVENTIVE EFFORTS. PRINCIPAL AMONG SUCH EFFORTS ARE THE ESTABLISHMENT OF EARLY CHILDHOOD PROGRAMS. WE KNOW WHAT TO DO TO PREVENT FAILURE, SO LET'S SPEND MONEY TO PREVENT FAILURE AND TO FIX THE EFFECTS OF FAILURE. FOR EXAMPLE, WE KNOW HEAD START MAKES A DIFFERENCE. YET, FEWER THAN 20 PERCENT OF THOSE CHILDREN ELIGIBLE FOR HEAD START RECEIVE SERVICES. JUST SUPPOSE WE COULD SPEND ADDITIONAL MONEY ON QUALITY PRE-SCHOOL PROGRAMS: WE COULD BREAK THE CYCLE OF THE MOTHER'S EDUCATION AS A PREDICTOR OF HER CHILD'S SUCCESS; WE WOULD HAVE KIDS WHO COULD ACTUALLY SAY "NO" TO DRUGS (TODAY WE WAIT UNTIL THEY'RE 14 AFTER IT'S TOO LATE) WE URGE YOUR SUBCOMMITTEE TO PROVIDE FUNDING FOR THE AUTHORIZATION OF AN EARLY CHILDHOOD INITIATIVE. SAFE, QUALITY EARLY CHILDHOOD EDUCATION AND CHILD CARE ARE IMPERATIVE TO THE WELL BEING OF OUR CHILDREN.

THERE ARE MANY WHO POINT TO THE BUDGET DEFICIT AND SAY THAT THE FEDERAL GOVERNMENT CANNOT AFFORD TO FUND ALL THESE PROGRAMS AFFECTING CHILDREN. BUT THE ISSUE IS NOT WHETHER OUR NATION CAN AFFORD THESE PROGRAMS, BUT WHETHER WE CHOOSE TO AFFORD THEM. EVERY YEAR, THE CONGRESS MAKES CHOICES, AND THIS YEAR IT'S TIME FOR CONGRESS TO CHOOSE OUR NATION'S CHILDREN.

MR. CHAIRMAN, NASBE IS READY TO WORK WITH YOU AND YOUR COLLEAGUES TO ASSURE THAT THE CHILDREN OF THIS NATION ARE WELL EDUCATED, WELL FED AND WELL CARED FOR. WE URGE YOU TO CONTINUE TO WORK WITH US AS WE MOVE FORWARD IN THE SERVICE OF OUR NATION'S CHILDREN. AGAIN, THANK YOU FOR THIS OPPORTUNITY.

STATEMENT OF GILBERTO de JESUS, EXECUTIVE DIRECTOR, COUNCIL ON LEGAL EDUCATIONAL OPPORTUNITY

Senator **Burdick**. Mr. Gilberto de Jesus, executive director, Council on Legal Education Opportunities.

Did I pronounce that right?

Mr. **de Jesus**. Close enough, sir. [Laughter.]

My name is Gilberto de Jesus, and I address you in my dual role as executive director of the Council on Legal Education Opportunity, better known as CLEO, and perhaps more importantly as a graduate of the program more than a decade ago.

I grew up in Spanish Harlem in New York. Today, the euphemism I guess we use is "inner city." Back then, we called it a ghetto or slum, but it does not matter, really, what we call it.

When we refer to such names as Watts in Los Angeles, Cabrini Towers in Chicago, or the Hamlets in Appalachia, what makes CLEO unique is that many people who have similar backgrounds as I do are attorneys today, and they are attorneys because of the CLEO program.

CLEO has been in operation now since 1968, when it was created by private and Federal funds. Its purpose then, as now, is to serve those educationally and economically disadvantaged students who would otherwise have limited access to a legal education, for they, too, suffer from the disability brought on by poverty.

The CLEO program services those students who, because of less than traditional academic predictors, are unable to gain admission to the law schools. This is accomplished through an intensive 6 weeks residential summer program hosted by seven law schools nationwide.

From its very inception, the CLEO program has been based on shared risks and responsibilities between the Federal Government and the law schools.

For example, the $1.9 million we receive in Federal aid generates close to $3 million in outright scholarships and tuition for our students.

To date, CLEO has assisted over 4,800 economically-disadvantaged students to enter 160 accredited law schools throughout the country. Nearly 4,200 of these students have already graduated from law schools, and are now actively pursuing their careers in public service organizations, private law firms, Government agencies, and private industry.

Obviously, I cannot underscore enough the importance of a legal education. Of the 15 members who serve on this committee, all but two are attorneys. Our program has had major impact in the minority communities.

When you look at the leadership of the Hispanic National Bar, the National Bar Association, which is the black national organization for attorneys, you see that the leadership is disproportionately made up of members of the CLEO alumni organization.

CLEO is requesting $2.5 million in appropriations for 1990. This funding will allow us to increase the student scholarships, add additional students to institutes, and provide an increase in the Federal share that CLEO now contributes to operating the summer institutes.

For 1988, the costs of tuition and fees are up 5 to 8 percent, outstripping inflation for the seventh consecutive year.

Average total costs for students living on campus are just under $12,000 this year, with the more expensive schools just shy of $20,000.

The CLEO scholarship, while inadequate, does provide a minimal level of support for our needy students. Our scholarships have been modest in comparison to other federally funded programs.

For example, the federally funded graduate professional programs such as GPOP public service and mining fellowships have provided stipend assistance of approximately $6,000 per year.

Currently, our first-year students receive a scholarship of $2,200, and our second- and third-year students receive scholarships of $2,000.

We propose to increase this level significantly in 1990. This scholarship is intended to defray the substantial financial burden incurred in law school for tuition and living expenses.

Another point I would like to make is that our applications have increased considerably this year. We have received 2,000 applications, an increase of 400 from last year.

One of the things we would like to do, also, is increase our institutes and the numbers of students we can accommodate in those institutes.

As I indicated earlier, the success of the program has been predicated on the support that we have gotten from the law schools. When we originally started in 1968 the law schools contributed 30 to 40 percent of underwriting the expense of the summer program. Now they contribute 60 percent.

What we find now is that our share, the share that we contribute to the law schools, has shrunk considerably, and our major concern is the ability to retain faculty quality.

As it stands now, our faculty has virtually continued to receive the same salary that they received 20 years ago. It is a tribute to their dedication that we are able to get people who are willing to help our students and work for 6 weeks.

Our program has been also extremely cost-effective. A couple of years ago, we had 11 full-time staff; now we are down to 7.

PREPARED STATEMENT

In conclusion, what I would like to say is that the CLEO program has worked because of the vision that the law schools and the Federal Government had 20 years ago. It continues to work today.

We hope to see that law school does not become an elusive dream for many of our students. There are still many students out there that we turn away, and we would like to help them.

Thank you very much.

Senator BURDICK. Thank you.

I notice that this fiscal 1990 appropriation is $1.96 million, and 1989 is $1.89 million, so there is an increase there over last year, is there not?

Mr. DE JESUS. Yes, sir.

We are requesting an increase.

Senator BURDICK. There is an increase.

Mr. **de Jesus**. Pardon me?

Senator **Burdick**. There is an increase, in the President's request.

Mr. **de Jesus**. What I understand that the increase is——

Senator **Burdick**. He has requested the appropriation for 1989, $1.89 million. He is now requesting $1.96 million.

Mr. **de Jesus**. Yes, sir.

Senator **Burdick**. Thank you.

Mr. **de Jesus**. Thank you.

[The statement follows:]

STATEMENT OF GILBERTO DE JESUS

On behalf of the Council on Legal Education Opportunity (CLEO), I submit this testimony regarding the appropriation of Assistance for Training in the Legal Profession, Title IX, Part D of the Higher Education Act of 1965, as amended, pursuant to which CLEO undertakes activities to assist individuals from disadvantaged backgrounds to obtain a legal education.

CLEO has been in operation since 1968 when it was created by private and federal funds. It's purpose, then as now, is to serve those educationally and economically disadvantaged students who would otherwise have limited access to a legal education. Today, a legal education continues to remain an elusive dream for many. For example, in 1982 the Bureau of Census reports that of 606,000 lawyers in the United States, only 3.6% were members of a minority group. Currently, this percentage has increased to just over 4% of the more than 650,000 lawyers nationally. Indeed, CLEO is perhaps more important now than it was twenty years ago, when one considers that Black student enrollment has never exceeded the 4.12% total they registered in 1976-77. Hence, not only are Black, American Indian, and other minority groups still underrepresented in law schools, but the proportion in total law school enrollment of minorities, especially Mexican-Americans and Puerto Ricans, is declining.

The CLEO Program serves those students who, because of less than traditional academic predictors, are unable to gain admission to law school. This is accomplished through an intensive, six-week residential summer program hosted by seven law schools nationwide.

These Institutes prepare and identify students to successfully complete law school by providing a curriculum based on legal analysis, abstract thinking, law development, and legal research and writing techniques. The faculty's primary responsibility is to evaluate each student's potential for successfully mastering the law school curriculum.

To date, CLEO has assisted 4,831 economically and educationally disadvantaged students to enter 160 accredited law schools throughout the country. Nearly 4,204 of these students have already graduated from law school and are now actively pursuing their careers in public service organizations, private law firms, government agencies and private industry.

This year we are requesting $2.5 million dollars. This funding will allow us to 1) increase the stipends which our students now receive; 2) add additional students per Institute; and 3) provide an increase in the (Federal) share CLEO now contributes to operate the Summer Institutes.

For 1988, the cost of college tuition and fees are up 5 to 8 percent, outstripping inflation for the seventh consecutive year. Average total costs for students living on campus are just under $12,000 this year, with the more expensive schools just shy of $20,000.

The scholarship, while inadequate, do provide a minimum level of support for the needy students which the program services. Our stipends have been modest in comparison to other similar federally funded programs. For example, federally-funded graduate and professional programs such as GPOP, Public Service and Mining Fellowships, have provided stipend assistance of approximately $6,000 per year and some have had institutional support components as well. This disparity in funding levels for students funded through similar federal programs under the same legislation has substantially hampered CLEO's ability to recruit students who would otherwise like to pursue a legal education. It was to correct this disparity in assistance, coupled with the program's impressive record of achievement, that encouraged Congress in 1980 to amend the Legal Training for the Disadvantaged Program legislation to provide new appropriation ceilings under the reauthorized Higher Education Act of 1965, as Amended.

Currently, our first year students receive $2,200 and our second and third year students receive $2,000. We propose to increase this level significantly in 1990. The stipend is intended to defray somewhat the substantial financial burden incurred in law school for tuition and living expenses.

For this academic year, we received over 2,000 applications. This is an increase of 400 applicants over 1988. Given the tremendous increase in a two-year period (1987-88), in contrast to an average of 1,400 applicants in the early 1980's, CLEO proposes to increase the enrollment of the Summer Institutes to serve a total of 252 students.

CLEO's success is due in large part to the support and generosity of the law schools which contribute financially and materially to the operation of the Institutes. While their support has been constant for twenty years, it has not been able to keep pace with increases associated with conducting the Summer Institutes. Initially, the law schools were contributing up 30-40% of the total cost of carrying out the Institute. Today, however, they absorb a disproportionate 60-70% of the costs. If CLEO is to continue to attract and retain quality faculty, we must compensate them accordingly; in twenty years, faculty salaries have remained virtually unchanged. We therefore propose increasing CLEO's contribution to each Institute to cover the costs associated with a larger student enrollment and the need for additional faculty.

It is important to point out at this juncture that the $1.9 million of annual federal support for this program generates over $3,000,000 in cash and services annually from the law schools in the form of tuition scholarships, as well as other forms of financial support in recognition of the economic needs of the students served by the Program. We believe this private/federal partnership has worked well.

The Program has been and is cost-effective. While many programs have suffered substantial cost increases in their operating and overhead budget over the years, CLEO has been a rare exception. In the last eight (8) years, the program has continued to service successfully its disadvantaged student population with only modest increase in cost to the federal government. Judicious cost-saving measures have been implemented over the past several years with an eye toward fiscal austerity, including executive staff salary freezes and significant reduction in program staff; once staffed by eleven permanent employees, the program now operates with a staff of seven. A careful review of the program's budget already reveals a "bare-bones" operation.

The federal government has made a major commitment in the last two decades to increasing educational opportunities for the poor and disadvantaged groups within society. This is an important commitment not only in terms of fairness, but also in terms of wise allocation of resources. Compared to many federal support programs, CLEO is impressive because the payoff is concrete, clear and quick. The modest federal support is matched several times by the substantial voluntary contributions of the law school community and is repaid to the government many times over in higher taxes from these individuals and in their service to society.

Observing the demonstrated success of CLEO participants and the continued support and cooperation of the nation's law schools, we request that you appropriate funds to Legal Training for the Disadvantaged at the level of $2.5 million for FY 1990. This amount would permit CLEO to immediately increase student awards to approximately $2,700 for all three years of law school at an overall increase of $1,730,000; even this level of support would not achieve parity for the program with grants being awarded by other Title IX programs. It would also allow us to increase CLEO's share to host the Institutes. The proposed request of approximately $315,000 for 1990 Summer Institutes will enable CLEO to admit 252 students into that year's program, thus significantly increasing the number of participants served.

In many ways, CLEO serves as a model of financial integrity. it is also an outstanding example of government partnership with the private sector in furtherance of significant social goals. Legal Training for the Disadvantaged provides a long-term strategy for increasing the number of underrepresented minorities who seek to prepare for a legal career.

For these reasons, the CLEO program merits ongoing support to continue its important and highly successful work.

Thank you for your time and consideration.

STATEMENT OF CHARLES R. THOMAS, AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

Senator **BURDICK**. Dr. Charles Thomas, American Association of School Administrators.

Dr. **THOMAS**. Mr. Chairman, my name is Charles Thomas. I am a superintendent of schools in the North Chicago Public Schools in North Chicago, IL.

I am also chairman of the Committee on Federal Policy and Legislation for the American Association of School Administrators [AASA], on whose behalf I am appearing today.

I would like to thank you, Mr. Chairman, for giving me the opportunity to present the views of more than 18,000 local school superintendents and school executives who are members of AASA.

Our message this year is a very simple one. We firmly believe that given the clear national consensus among researchers, practitioners, business people, for early childhood intervention, you should direct your resources toward the chapter I program, the Head Start program, and education for the handicapped.

Full funding to reach all 10 million chapter I eligible children would bring that program from its current level of $4.1 billion to approximately $9.1 billion. And for Head Start to reach all 2.5 million eligible children, it must grow from the current $1.2 billion level to $6.6 billion.

The major obstacle to achieving adequate funding is, in general, the Federal expenditure pattern. Only debt service, entitlements, and defense are growing.

Discretionary spending is being strangled. Some programs will continue to grow in the short term, but not enough to actually expand services to more children, or to improve programs now in place.

This situation is intolerable and should not continue to exist. With this in mind, we specifically recommend the following allocations; $317 million in new dollars, the maximum allowed under the new authorization, to Head Start, bringing that program to a total funding level of $1.5 billion for fiscal year 1990; $670.6 million new dollars, a $500 million increase beyond inflation, as specified under H.R. 5, to the chapter I program, bringing that program to a total funding level of $4.833 billion for fiscal year 1990; and $200 million new dollars for the State grants under education for the handicapped, bringing that funding level to $2 billion for fiscal year 1990.

Public Law 94-142, under which these funds are distributed, holds out the promise for a 40-percent Federal share.

Mr. Chairman and members of the subcommittee, we appreciate the help that you have given to education in the past. We further believe that the budget agreement reached by the President and the leadership of the Congress contains sufficient authority to allow you to adopt this investment.

PREPARED STATEMENT

We, at the American Association of School Administrators, thank you for your past commitment to our young people through the Federal education programs, and we urge you to continue placing education through your fiscal year 1990 appropriations bill at the top of the list for this Nation's education priorities.

Thank you very much, and I would be very happy to answer any questions which you might have.

Senator BURDICK. I notice that the President's request increased spending over the 1989 fiscal year in Head Start, chapter I, and handicapped State grants—all three categories.

Dr. THOMAS. Yes, sir.

We respect the increases. Our concern is that we serve those youngsters who are eligible—all of those youngsters.

Senator BURDICK. You are concerned that what?

Dr. THOMAS. That we serve all of the youngsters who are eligible to be served in those programs.

We appreciate the increase.

Senator BURDICK. Thank you.

[The statement follows:]

STATEMENT OF CHARLES R. THOMAS

Mr. Chairman and members of the Subcommittee. My name is Charles Thomas, and I am Superintendent of Schools for the North Chicago Elementary School District in North Chicago, Illinois. I am also a Chairman of the Committee on Federal Policy and Legislation of the American Association of School Administrators, on whose behalf I am appearing today.

I would like to thank you, Mr. Chairman, for giving me this opportunity to present the views of the more than 18,000 local superintendents and school executives who are members of AASA. We are grateful to you and the members of this Subcommittee for your past support for public education and look to you to lead the way to launch significant new investments in education throughout the difficult budget years ahead.

Mr. Chairman, our message this year is a simple one. We firmly believe that, given the clear national consensus--among researchers, practitioners and businesspeople--for early childhood intervention; you should direct your resources toward the Chapter 1 program, the Head Start program, and Education for the Handicapped.

As the Committee for Education Funding so graphically demonstrated in its January 5 position statement, education has fallen--despite the valiant efforts of this Subcommittee--from 2.5 percent of the federal budget in Fiscal Year 1979 to just 1.7 percent of the budget in Fiscal Year 1988. Investment in elementary and secondary education, where the most attention must be focused before we lose an entire generation of productive citizens, has suffered even more, since none of these vital early childhood programs enjoys entitlement status.

Meanwhile, we have seen the poverty rate among children grow from some 16 percent in 1979 to more than 22 percent in 1988. And, as the Congressional Research Service reported last November, every major industrialized nation (Canada, Japan, Sweden and the United Kingdom) achieves higher mathematics scores than U.S. 17 year-olds, while Japan devotes nearly five percent more of its government expenditures to all levels of education than the U.S., and Canada and Sweden both spend higher percentages of their gross national products on education than the U.S.

As the Committee for Economic Development (CED) stated two years ago, Mr. Chairman, "This nation cannot continue to compete and prosper in the global arena when more than one-fifth of our children live in poverty and a third grow up in ignorance...If we continue to squander the talents of millions of our children, America will become a nation of limited human potential." The CED subsequently recommended that, because they have had "demonstrable success," funding for both the Chapter 1 and Head Start programs should "be brought up to levels sufficient to reach all eligible children."

Full funding to reach all 10 million Chapter 1 eligible children would bring that program from its current level of $4.1 billion to approximately $9.1 billion. And for Head Start to reach all 2.5 million eligible children it must grow from the current $1.2 billion level to $6.6 billion.

We recognize that in the current budget climate, Mr. Chairman, such figures are not attainable this year. However, we have reached the point where we must stop making that statement year after year. Too many young lives are being swallowed up in despair, too many futures are being ruined--right now--because we are failing to make our children a national budget priority.

The major obstacle to achieving adequate funding is the general federal expenditure pattern. Only debt service, entitlements and defense are growing. Discretionary spending is being strangled. Some programs will continue to grow in the short term, but not enough to actually expand services to more children or improve programs now in place.

This situation is intolerable. Poverty rates for children and indicators of family instability are rising. There are sound demographic and economic reasons to worry about this generation of youngsters. But, more importantly, morality and humanity demand our concern about the most disadvantaged children.

With all this in mind, we urge you to allocate:

*$317 million new dollars, the maximum allowed under the new authorization, to Head Start, bringing that program to a total funding level of $1.552 billion for Fiscal Year 1990. This increase will, after paying $50.6 million to cover the cost of inflation, enable 100,000 more eligible children to receive vital Head Start services, and will thus enable local communities to hire 11,111 new Head Start teachers and aides.

*$670.6 million new dollars (a $500 million increase beyond inflation, as specified under Sec. 1001 (a)(2)(B) of P.L. 100-297) to Part A "Grants to Local Educational Agencies" of the Chapter 1 program, bringing that program to a total funding level of $4.833 billion for Fiscal Year 1990. This increase will enable Chapter 1 to reach 833,000 of the eligible children who currently cannot receive extra reading and math help, and will also enable local schools to hire 41,650 new Chapter 1 teachers.

*$200 million new dollars to State Grants under Education for the Handicapped, bringing that program to $2.044 billion for Fiscal Year 1990. This increase, after paying $75.6 million to cover the cost of inflation, will enable the federal government to bring its share of average per pupil expenditures for the education of handicapped children up slightly from the nine percent share provided today. Public Law 94-142, under which these funds are distributed, holds out the promise of a 40 percent federal share.

Mr. Chairman and members of the Subcommittee, we believe these amounts represent the minimum investment you should make in education for the coming year. We further believe that the budget agreement reached by the President and the leadership in Congress contains sufficient authority to allow you to adopt this investment.

We at AASA thank you for your past commitment to our young people through the federal education programs, and we urge you to continue placing education, through your Fiscal Year 1990 appropriations bill, at the top of this nation's list of priorities.

STATEMENT OF CHARLES B. SAUNDERS, JR., SENIOR VICE PRESIDENT, AMERICAN COUNCIL ON EDUCATION

Senator **Burdick**. Charles Saunders, senior vice president, American Council on Education.

Mr. **Saunders**. Good morning, Senator Burdick.

Senator **Burdick**. Good morning.

Mr. **Saunders**. I am Charles Saunders of the American Council on Education. I believe you have our testimony on behalf of 11 associations representing all sectors of higher education.

I would just like to comment on a couple of the highlights of that testimony.

Senator **Burdick**. Fine.

Mr. **Saunders**. The statement—our statement includes two charts. One of them shows that Federal aid is the primary source of postsecondary educational opportunity in this country, providing 75 percent of total national expenditures. But that at the same time, needy students over the last decade have been increasingly forced to borrow for their education, rather than receive grant assistance.

The second chart shows that the value of Pell grants has been eroding steadily, as well as the value of other student aid, even though expenditures have risen substantially in recent years.

That really sums up the basis for the recommendations made in our testimony, Mr. Chairman, to increase grant aid, particularly for Pell grants and supplemental grants, to reduce that reliance on loans which has grown so tremendously over the last decade.

As our testimony notes, a decision not to increase the Pell maximum is, in effect, a decision to reduce aid to the neediest students, and to cut middle-income students out of the program altogether, which is the way the formula operates when there is no increase in the maximum.

Similarly, a decision not to provide a significant increase for supplemental grants is a decision, in effect, to reduce aid to the neediest students in the collegiate sector, aspiring to a bachelor's degree, because of the increase of low-income recipients in the proprietary sector.

I am certainly not here to suggest that needy students in the proprietary sector are any less needy. I am simply pointing out that the purpose of the program is to meet the needs of students in both sectors, and the way that formula operates, additional money in the program goes to new schools, and the growth of the proprietary sector in recent years is such that it would take a substantial amount of additional money in that program to put any new money into the collegiate sector.

PREPARED STATEMENT

Our statement also asks for increases in related programs including graduate programs, a modest $17 million to encourage more minorities in graduate education and to lay the basis for providing the increased number of Ph.D.'s that are required in the 1990's, and who should be entering graduate school now.

We also ask for increases in the TRIO programs and for developing institutions, title III, to assist disadvantaged and minority students particularly.

In closing, Mr. Chairman, I would just like to thank you for your support of these programs over the years.

Thank you.

Senator BURDICK. Thank you.

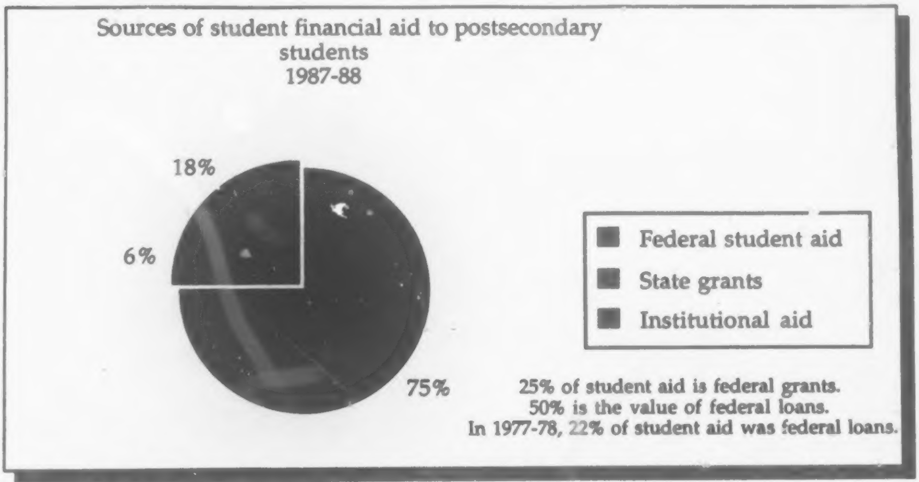
[The statement follows:]

STATEMENT OF CHARLES B. SAUNDERS, JR.

Thank you for this opportunity to present the joint recommendations of the higher education community on FY 90 appropriations for Education Department programs.

Two charts included in our testimony provide the basis for our recommendations:

Chart #1 emphasizes that federal student assistance programs provide the primary means of achieving America's goal of equal educational opportunity. Without these programs, state and private efforts could not begin to approach the level of opportunity that exists today. The chart also shows that two-thirds of the federal contribution now consists of loans--a disturbing trend which has reversed the pattern of a decade ago, and forced needy students to borrow a much greater share of their educational costs.



Sources of student financial aid to postsecondary students 1987-88

25% of student aid is federal grants.
50% is the value of federal loans.
In 1977-78, 22% of student aid was federal loans.

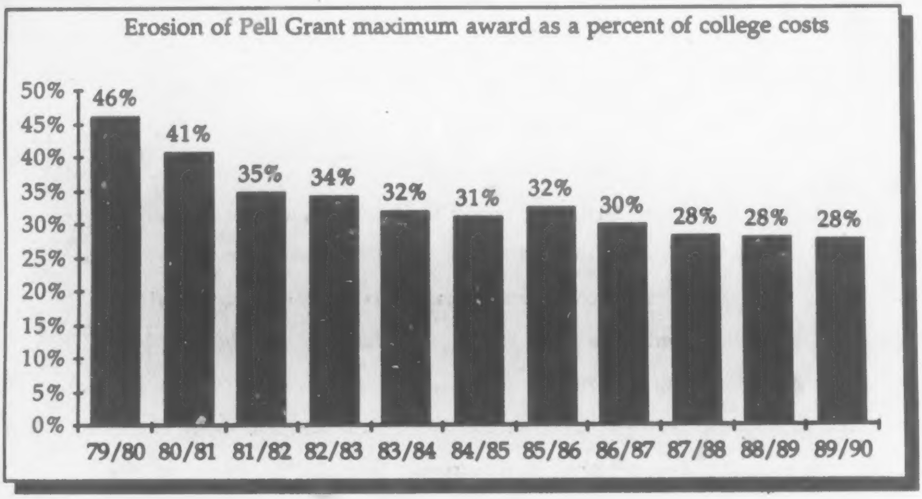
Source of data: College Entrance Examination Board Washington Office

Chart #2 illustrates the steady decline of the value of the Pell Grant maximum award in recent years, at a time when total expenditures for the program have risen by 90 percent. Over the period, the value of the maximum award has eroded some 25 percent as measured by the CPI, and 40 percent measured by college costs. Other Title IV student aid programs have also suffered serious erosion: appropriations for Supplemental Grants have dropped 31 percent compared to CPI, College Work-Study 35 percent, State Student Incentive Grants 45 percent, and federal capital contributions for Perkins Loans, 62 percent.

Thus, our recommendations focus on the urgent need to sustain the primary federal role in student assistance, and in particular to increase grant

assistance to needy students sufficiently to reduce their reliance on loans, as follows:

* **We believe it is urgent that the Pell Grant maximum award be increased from $2300 to $2500. Increasing the maximum award is the only way to increase benefits for all eligible students, including the 1.6 million whose family incomes are so low that they are not expected to contribute to their education under the federal statute.**



During the past decade the maximum award has been increased only three times; it was actually reduced twice. During that period (from 1979 to 1989) the CPI increased 71 percent while the Pell Grant maximum increased only 28 percent. Thus, the maximum award decreased 25 percent in constant dollars between 1979 and 1989. A $200 increase in the Pell Grant maximum to $2500 for FY 90 would still represent an increase of only 39 percent since 1979; during that period the CPI will have increased almost 80 percent.

A major reason for the increasing demand for Pell Grant funding during the past decade has been the dramatic increase in low-income students in the program, who are eligible for high awards. The overall number of recipients has increased only 25 percent since 1979, but the number of very low-income students--those with no Expected Family Contribution (EFC)--has increased 65 percent, from 972,000 to 1.6 million. The number of recipients with EFC above zero declined from 1.57 million in 1979 to 1.07 million by 1986. (This decline is a result of the program formula, which removes a significant number of middle-income students from eligibility whenever the maximum award fails to increase.)

This increase in low-income recipients took place in all types of institutions, but was particularly prevalent in short-term private career school programs. The number of Pell Grant recipients in programs of one year or less increased from 150,000 in 1979 to 466,000 by 1986. During this same period, the number of recipients in four-year programs declined by over 300,000 (again, because of the effect of the formula in removing middle-income students from eligibility when the maximum award fails to increase).

Thus, increased funding for needy students in private career school programs is effectively reducing the amount of aid available for needy students aspiring to a bachelors degree or higher in the collegiate sector. If the maximum award is not increased regularly, the number of Pell Grant recipients in four-year institutions will decline further because these students come from families with slightly higher incomes, yet they have great need themselves for funds: their families are nearly all well below the median family income. In 1986-7, 82 percent of Pell Grant recipients came from families with incomes below $15,000, and only 8 percent came from families with incomes above $20,000.

This increased funding pressure is exemplified by the distribution of the increase in Pell Grant funds in 1987 versus 1986. The maximum award did not increase, but expenditures for the program rose $340 million. Half of that increase went to students in proprietary institutions, which have increased from 2,133 in 1980 to 3,042 in 1987--an increase of 43 percent compared to a 2 percent increase in non-profit collegiate institutions.

* It is equally urgent that funding be increased for Supplemental Grants (SEOG) and other campus-based programs. The statutory formulas for distributing these funds target increased appropriations on institutions in which the need is greatest, taking into account both cost of attendance and family income. All the campus-based programs require substantial institutional matching, and thus effectively leverage additional private support for needy students.

The SEOG program provides critical additional grant assistance to Pell recipients and those students with exceptional need. It is particularly urgent, in the absence of adequate Pell resources, that financial aid administrators have this kind of funding available to address the specific circumstances of the neediest students, and to minimize borrowing for high-risk students.

We recommend an increase of $200 million for the SEOG program, which would aid approximately 200,000 additional students and increase benefits for the 600,000 current recipients. An increase of this magnitude is important, in order for students in the collegiate sector to receive additional assistance: a more modest increase would be absorbed by newly-eligible institutions, which under the law receive priority for any funding increase, and which are predominatly in the proprietary sector.

We request an additional $100 million for the College Work-Study program, which provides jobs both on and off campus for needy undergraduate and graduate students, enabling them to cover a significant part of their college costs through employment rather total dependence on loans, and funding community service programs in many areas. This would provide funding for another 100,000 students in addition to the 700,000 already receiving benefits.

We recommend an additional $28 million for State Student Incentive Grants, which serve approximately 300,000 students and require 50 percent matching funds from the states. This program provides an essential incentive for need-based state grants and work-study programs; in nine states the federal contribution represents half of the total state program. We also propose an inflation increase in federal capital contributions to the Perkins Loan program, which provides low-interest loans to about one million needy students.

We also recommend an increase of $17 million for Title IX Graduate Education programs, from an aggregate funding in FY 89 of $43.2 million to FY 90 funding of $60.3 million. Graduate education produces the teachers, scientists, and scholars responsible for the delivery and dissemination of new knowledge and the preservation and interpretation of our intellectual and cultural heritage. Beginning in the mid-1990's, increased faculty vacancies and increased undergraduate enrollments will combine with a growing demand for Ph.D.s in nonacademic markets to increase sharply the need for doctorate recipients. The Ph.D.s that will be needed then should be entering graduate school now.

Increased funding for the Department of Education graduate programs wil directly address the supply of Ph.D.s by supporting more talented U.S. students in graduate study, including fellowships targetted on underrepresented groups, and summer research internships and related programs to interest minority undergraduates in careers in teaching and research and to prepare them for graduate study.

Our funding request would restore the Harris graduate fellowships to their 1986 level, provide for a new competition in the National Need Graduate Assistance program, assure stable support for the Javits fellowship program, and provide a modest increase in the highly effective minority undergraduate research internship program.

In addition to our recommendations for grant assistance to needy students, we urge increases totalling $114 million for categorical programs serving special national purposes:

* **Special Programs for the Disadvantaged (TRIO)** are of proven value in encouraging the participation and retention of disadvantaged youth in college. These programs--Upward Bound, Talent Search, Student Support Services, Educational Opportunity Centers, staff training grants, and the McNair Post-Baccalaureate program provide critical assistance to 500,000 students. We recommend a $50 million increase in funding for these programs, to increase the number of students served by 15 percent, to 577,000.

* **Title III, Developing Institutions**, addresses the specific developmental needs of historically Black colleges and universities and other institutions with large concentrations of minority, low-income students. Additional funding for this program is particularly important in the light of growing concerns that the educational system is not preparing adequate numbers of minority youths for careers in the sciences, teaching, and other professions. We recommend a $50 million increase for this important program.

* **Foreign Languages and Area Studies** contribute directly to strengthening America's economic competitiveness. Increased funding is needed to expand the knowledge and talent developed in these programs to improve understanding of other languages and cultures, and to help business compete more effectively in international markets. We recommend an increase of $14 million, including $7 million in the critical National Resource Centers program and an additional $7 million for three important new programs authorized in the Higher Education Amendments of 1986: advanced graduate fellowships, intensive summer language institutes, and language resource centers.

We recommend inflation increases for all other currently funded Higher Education Act programs, which provide incentives for institutions to strengthen their educational programs and improve their services to students.

STATEMENT OF STEPHEN J. BLAIR, PRESIDENT, NATIONAL ASSOCIATION OF TRADE AND TECHNICAL SCHOOLS

Senator **Burdick**. Stephen J. Blair, National Association of Trade and Technical Schools.

Welcome to the committee.

Mr. **Blair**. Thank you, Mr. Chairman.

My name is Stephen Blair, and I am president of the National Association of Trade and Technical Schools. I appreciate the opportunity to appear before the committee today and speak about the role of private career schools, and our efforts to reduce defaults and abuse in the Stafford Loan Program.

I would like to summarize my testimony and submit for the record my entire text.

There has been considerable attention paid and focused on default rate in private career schools over the last 1½ years. The perception is that we are the problem, but not part of the solution, and that, Mr. Chairman, is something that I would like to share with you, as to what we are doing.

Over 2½ years ago, we began the default management initiative. That initiative developed a manual and videotapes for entrance and exit interviews of students coming in and borrowing loans, student guides, and a joint sponsorship with State guarantee agencies. We conducted over 60 workshops.

We are releasing this month a consumer information book on how to select career and career schools. We are confident that this will assist students in making sound consumer choices.

Over the past 12 months, our accreditation commission has not renewed accreditation to 5 percent of the schools that were reviewed. We have also successfully fought and won the court challenges to those findings.

Also, 11 percent of the schools that applied for accreditation for the first time were denied. In addition, over the past 18 months, we have authored or supported 34 provisions to reduce defaults and abuse in the Stafford Loan Program.

In the recently passed Senate default legislation, 14 of the 30 default provisions were authored by private career school associations.

Some of the provisions that we authored would hurt our schools, but we believe that they are in the best interests of the program, the students, and the taxpayers.

In addition to these provisions, we have also authored provisions that would close down unscrupulous schools. These provisions are much needed, and are included in the Senate default legislation.

If we do not preserve the integrity of these programs in the mind of the American taxpayers, economic opportunity for many low-income, disadvantaged students who cannot be well served by traditional college experiences will be eliminated.

Mr. Chairman, in closing, I would simply like to share with you a story of one of our students, who recently graduated from a private career school.

His name is Kuang Ho, and he would not be here today without the assistance of financial aid. He was 4 years old when his father was taken prisoner by the North Vietnamese.

Seven years later, Kuang, along with his mother and seven brothers and sisters, left Vietnam the day before it was taken over by the North Vietnamese. After months of boat travel, and considerable trial and tribulation, they ended up in Denver with church support.

The year Kuang graduated from high school, his mother died in an automobile accident, and he and his older sister were left with the responsibility of raising their six brothers and sisters. After high school, Kuang applied for admission and was accepted to the Colorado Institute of Art in Denver.

He received a partial scholarship from the school, but the remainder of his tuition was paid for by Pell and Stafford loans.

Kuang graduated from the school and currently works as a freelance illustrator and artist whose clients include Coors and Blue Cross & Blue Shield, and his work has appeared in newspapers and magazines nationwide.

Without Federal financial assistance, without the opportunity to choose a postsecondary education which matched his interests and his talents, and without the condensed career-oriented program that is unique to the private career school sector, Kuang Ho would not be where he is today.

High-risk students are having to rely more and more heavily upon loans to finance their postsecondary education. Everything possible must be done to reduce defaults. However, caution must be exercised in modifying the current program so that the most needy population is not inadvertently excluded, because of well-meaning concerns about defaults.

Clearly, Mr. Chairman, we want to be part of the solution. However, there must be an effective partnership amongst all the parties involved in the administration and oversight of these programs, as well as vigorous prosecution of criminal wrongdoing.

PREPARED STATEMENT

All of us will either share in the blame for the failure of these programs, or the responsibility for their continued success.

We stand ready to assist in guaranteeing their success.

Thank you, sir.

Senator BURDICK. Thank you, sir.

[The statement follows:]

STATEMENT OF STEPHEN BLAIR

Mr. Chairman, members of the Subcommittee, thank you for allowing me to provide testimony this morning. I am Stephen Blair, President of the National Association of Trade and Technical Schools. I am here today to try and answer some hard questions the Congress has posed regarding private career schools and student loan defaults.

I will first provide an historical context to help put private career schools and their mission in perspective. Not much is known about their history or the role they have played in the American economy for hundreds of years.

History of Private Career Schools

Traditionally, preparation for the trades was done through apprenticeship. As specialization increased, so did the formality of the apprenticeship training. In the 16th and 17th centuries, governments often sponsored extended apprenticeship programs in lieu of welfare, a concept not much different than the current movement toward workfare.

The apprenticeship system began to disintegrate in the 18th and early 19th centuries in response to industrialization. It was replaced by formal trade schools and the introduction of vocational education in the high schools.

Beginning in the early 18th century, the first American private resident schools were conducted by "proprietary-masters" in their homes or business establishments. They advertised their services as masters in navigation, practical mathematics, surveying and business skills. These schools were the most popular form of secondary education in the 18th century. It must be remembered that colleges of that age did not teach practical skills such as mathematics or grammar. Mathematics, navigation, bookkeeping, shorthand, surveying, grammar and other practical skills were only taught in proprietary schools.

Private career schools were often the first to respond to demands for training generated by the introduction of new technology in business or industry. With the passage of the Morrill Land-Grant College Act in 1862, vocational education was first recognized as a public responsibility. It was not until the 1890's that vocational education was widely available in public schools. That is over a hundred and fifty years after proprietary education had blazed the way. Private career schools were the pioneers in developing the concept of career specific education and the curricula that were later utilized by the public vocational schools.

Today, colleges and universities are providing a curriculum that is predominately vocational in nature. Business, education and other applied majors dominate degrees given annually. As the content of traditional education has changed over the years, private career schools have continued to evolve and enter new fields. They continue to innovate and precede traditional colleges in preparing students for new specialties required by the changing needs of the labor market.

The genius of these schools is the rapidity with which they are able to meet new demands. Our national competitiveness depends in large part on the ability of machinists, tool and die designers, and engineering technologists--all trained in private career schools. The aging population results in the need for more medical technicians, optometric assistants, and dental laboratory technicians--all trained in private career schools. Changes in our living styles result in demands for more professional cooks, travel agents, and television production specialists--all trained in private career schools. Private career schools train specialists in hundreds of areas from actors to X-ray technicians. For every college educated worker there is need for several technicians and support staff.

Today, private career schools in America are the major provider of career specific education of under two-years in duration. The 1.7 million private career school students are nearly all enrolled full-time. Each year, community colleges are estimated to enroll about 1.1 million full-time-equivalent students in vocational training. Other vocational schools are estimated to enroll less than 300,000 students nationally. (see Table 1)

The achievements of private career schools have remained largely unknown because they have been ignored by academic educators and the Department of Education. The owners and administrators of private career schools have done little in the past to explain their schools operations and accomplishments.

Graduation and Placement

According to recent research, private career schools enroll a larger share of minority students, women, and low income students compared to community colleges and four-year colleges. What is even more gratifying is the economic success these students have as a result of their education. The completion rate of private career school students exceeds that for community colleges. Over 63 percent of the enrollees in private career schools receive a degree or certificate compared to about 43 percent for community colleges. This success is on par with traditional colleges. (See table 2)

The private career school student receives compensation for completing his or her program. Graduates of private career schools earn more six years after high school than any of their peers regardless of the type of education received. Private career schools are successful at taking low-income, non-academic students and moving them into high paying jobs. (See table 3)

In short, private career schools are a proven success in helping students of both genders who are low-income and of different racial and ethnic backgrounds achieve their financial goals. The Congress has identified this objective as the primary reason for instituting federal student aid programs.

Private career schools complement traditional college programs. They provide an opportunity for low income citizens to move quickly into the labor market. They stress the development of hands-on skills, a specific curriculum of study, and assistance in job placement. They serve students with different levels of skills and aptitudes, many of whom are not prepared to succeed in college but need increased skill levels to move into good paying jobs.

Guaranteed Student Loan Defaults

In the continuing debate about Guaranteed Student Loan defaults, it should be kept in mind that the rate of default has remained roughly the same over the last twenty years, although defaults are currently on the decline. As a result of the larger number of new loans being made, the volume of defaults has increased. The greater amount in default reflects the growing volume of loans entering repayment over the last decade.

The Department of Education reports defaults as cumulative gross defaults which do not reflect the success in returning defaulters to repayment. But there has been increasing success in turning defaulted loans around over the last few years. Dollars lost to defaults are overstated by roughly one-third if gross default numbers are used.

Several points need to be kept in mind regarding the debate about defaults. First, we need to be clear that a large number of private career schools have always had low student loan default rates. Second, a number of traditional colleges and schools have high default rates. Third, a number of private career schools identified with high defaults are no longer in business. Fourth, a large number of schools have developed counseling and management programs over the last two years designed to reduce student loan defaults. The effect of these and other legislative and administrative efforts to reduce defaults are just becoming evident.

For some there will always be a default rate higher than acceptable. Compared to other federally guaranteed loans, however, the rate is not excessive. It is heartening to note that the default rate in the Stafford loan program is starting to decline in response to the efforts of the last few years.

Private career schools are likely to continue to have higher than average numbers of students defaulting. This is not a sign of bad schools. It is a function of the students educated by private career schools.

The most common student characteristic associated with defaulting is poverty at the time the loan is taken. Low income students have higher default rates than high income students. Other characteristics associated with defaults include being independent of parent's income, being black, and living in a large city. Low academic ability students have higher defaults than high academic ability students. The following table demonstrates that students located in the inner-city have a higher default rate than students with the same income in other neighborhoods. (See table 4)

This risk profile describes the student body of private career schools more closely than other types of schools. Compared to students in other types of postsecondary schools, private career school students tend to be poorer, minority, female, less academically prepared and often located in lower income neighborhoods. All of these student characteristics are also associated with higher defaults and combine to push defaults up for the schools that serve them.

Private career schools have a long history of educating students not served by traditional colleges. They provide programs not available other places. Students choose private career schools in preference to other options because they better serve their needs. The completion rates and incomes quoted earlier indicate that for them, this is a wise decision.

The profile of the potential defaulter is the same as the person federal student aid programs are designed to help. If Congress reduces access to Stafford loans for these students, the educational options for poor students will be significantly reduced. It will result in educational exclusion for the poorest in our society. We as a nation do not want to be accused of educational redlining by only making education available to those we think will be able to repay their loan.

There is a high cost to serving the needs of poor students. By focusing exclusively on the cost of defaults, we may lose sight of the value of serving these students. The long-term benefits of investing in these students is much larger than the benefits of investing in wealthier students. Providing the skills for an underclass young person to enter the job market may result in keeping them off welfare, out of trouble with the legal system or not included as another poverty statistic. Society saves twice, once by the increased taxes paid by a skilled worker and once by the social support costs saved.

Accreditation

Much of the concern about defaults is premised on the assumption that a good deal of the default problem in the private career sector is generated by unethical schools. This has been reinforced by a spate of news stories focusing on problems in the industry. A review of news articles over the last three years identified 81 schools that had been recognized by name as operating in a questionable manner. This is less than two percent of the accredited private career schools in the nation. A number of the stories were about the same half-dozen schools or chains. Often, these schools were in the process of losing accreditation as the story was being written. (See Table 5)

The accreditation process required of schools in the private career school sector is more rigorous than that faced by traditional colleges. There is a simple reason for this, we stress outcomes, not just inputs. Schools must have successful retention and placement experience or they are denied accreditation.

A school faces an accreditation visit every five years. A pattern of complaints by students, or a state or federal agency can trigger a special accreditation visit. The visiting team includes representatives from industry, traditional colleges, other schools and accreditation commission staff. Every aspect of the school's operation is scrutinized.

Last year NATTS refused accreditation to five percent of the existing schools and ten percent of the new applicants. Other private career school accrediting commissions have similar records. We continue to review and tighten our accreditation standards to provide even more assurance that an accredited school provides a good education. The members of the private career school associations understand that the questionable behavior of the few casts a shadow over the many.

Yes, there are problems. A school which is denied accreditation must be given due process which means that months and even years can go by before a questionable school finally loses accreditation. A renegade school can leave one accrediting commission and seek approval by another, thus escaping the loss of accreditation. We all need to work more closely together to close these and other loopholes. Accrediting commissions, state licensing agencies and federal regulators need to work together to reduce the possibility of fraud in educating students. In doing so, we should not reduce the availability or effectiveness of job specific education available to poor students in this country.

Conclusion

Private career schools have a long and honorable history in this country. Employers have come to depend on their graduates as a continuing source for skilled employees. Private career schools provide an opportunity for young people to obtain the education they need to enter the job market which demands increasingly technical skills. Over the long haul, private career schools provide an inexpensive educational option, costing the taxpayers much less than sending students to more expensive public programs. Private career schools provide a positive complement to the mission of traditional colleges and community colleges in this country.

Accreditation, state licensing, and federal oversight are beginning to work together to make sure that unethical schools have less opportunity to operate. We clearly have more to achieve. I have suggested some approaches to solving the problem in this testimony. The appended list of recommendations represent suggestions made by NATTS over the last year-and-a-half. The list includes recommendations for legislation, regulations, accrediting bodies and other state and federal agencies. If it pleases the Chairman, we ask that this list be included in the record. We need to close existing loopholes which have been used by individual schools intent on defrauding students and the government.

The private career school community is concerned about defaults and has been working to help reduce them. Private career school default management materials developed cooperatively by NATTS and AICS have been used nationally by schools, community colleges, states, guarantee agencies, and lenders to help reduce defaults. We hope the effort is successful, because we do not think it is fair to force low income, high-risk students out of appropriate educational options because of their high potential for default.

MATTS LEGISLATIVE/REGULATORY PROPOSALS TO REDUCE DEFAULTS & ABUSE IN THE STAFFORD LOAN PROGRAM

Lenders

Require multiple disbursement of SLS loans as required in the regular Stafford program.

Authorize lenders and servicers to place borrowers in deferment status based on information provided by borrowers in order to prevent technical default. If the borrower is subsequently found to be ineligible for a requested deferment, the borrower shall be returned to repayment and the incorrectly deferred principal payments and interest shall be capitalized.

Clarify that no Stafford may be made for an amount greater than the amount requested by the student and certified by the institution.

Recommend that lenders and servicers should be required to establish contact with the student during the grace period by mailing a form letter to the borrower to indicate how many more months the borrower has before the loan goes into repayment.

Borrowers

Require institutions to hold the first loan disbursement of a first year student until that individual has completed at least two weeks of classes. The institution may disburse up to 60 percent of other Title IV student aid funds to students during this two week period for non-tuition and fee expenses.

Limit the number of Staffords to two in a calendar year, where the borrower is otherwise eligible.

Require that a student's eligibility for a Stafford be determined before such student is eligible for a SLS or in the case of an independent student, a PLUS.

Amend Sections 484(d)(2) and (3) of the HEA, (Ability to Benefit) to require both testing and counseling for students who are admitted to a program under provisions contained in this section.

Department of Education

Prohibit any L S & T actions that are based solely on the default rate of the institution.

Require the Secretary to develop standards for the review of institutions that shall consider: the high-risk nature of the student body population and its historical propensity to default, the efforts of the institution to reduce defaults and the economic and employment condition of the area(s) served by the institution.

Allow the Secretary and the guaranty agency to impose fines on lenders and education institutions for willful errors in administering federal student assistance programs, in addition to requiring such errors to be cured or remedied. A schedule of such fines shall be defined in regulations and shall be based on the magnitude and the recurrence of such errors.

Require the Department to develop an annual plan for conducting program reviews of institutions, lenders, and guaranty agencies. This plan shall be published in the Federal Register for comment. The Department shall report to Congress the results of these reviews. A state guaranty agency shall focus its program review activity on institutions and lenders who, in the judgment of the guaranty agency, exhibit characteristics which indicate that they may be experiencing difficulty in administering the Stafford program.

Establish a set of common definitions for defining defaults and require that the definition be used by the Department of Education and participants in the program for all calculations and actions. Such definitions should cover gross and net calculations for both annual and cumulative default rates. Require that any presentation by the Department of Education of default rates or costs, particularly comparing different yearly data, use these consistent definitions and calculations.

Require the Department of Education to develop and implement a pilot program to study the feasibility of requiring borrowers to begin monthly repayments of $10.00 a month 30 days after the loan is disbursed for the in-school and grace periods.

- This payment will be collected by the institution and then forwarded to the lender to be credited as a prepayment to the student's loan principal.

- The institution will monitor the student's repayment schedule and in the event that the student fails to make a timely repayment, the institution shall provide additional borrower counseling.

Guarantee Agencies

Require Guaranty Agencies periodically to provide institutions with a list of defaulted borrowers so that institutions have the opportunity to provide additional information that could help locate the student.

Require guarantee agencies to provide preclaims assistance.

Institutions

Recommend that each institution conduct an entrance interview for all first time borrowers before the first check is disbursed. At this time, the student should sign a "rights and responsibilities" contract, and the institution should encourage that each student re-sign the "rights and responsibilities" contract during the exit interview. Counsel students in this interview that loans are to be used only as a last resort to financing their education.

Allow institutions to cancel or reduce the disbursement of the second installment of a Stafford for students who receive additional financial aid from other sources. Such funds shall be credited to the student's loan principal in the form of a prepayment.

Require that no institution be certified or recertified for program eligibility in Title IV of the Higher Education Act if such institution has had its accreditation withdrawn, revoked, or otherwise terminated for cause during the prior 12 months; or has withdrawn from accreditation voluntarily while under a show cause or suspension order during the prior 12 months.

Other

Deny Title IV eligibility to any institution which uses non employee personnel working on a commissioned basis to recruit students.

- o Remove eligibility for federal aid from institutions whose accreditation has been withdrawn for cause during the previous 24 months, and require those institutions which voluntarily change accrediting agencies to demonstrate their integrity to the Secretary.
- o Allow the Secretary to initiate L S & T actions against institutions which withdraw from a recognized accrediting body during a show cause or suspension proceeding.
- o Require institutions which have more than one institutional accreditation to identify which applies for Title IV eligibility purposes.
- o Exempt actions of a recognized accrediting body from the limitations imposed by the federal bankruptcy code.

Default Management Plan For Eligible Institutions

The Default Management Plan should be a matter of negotiation between the responsible guarantee agency and the school but approved by the Department. It should generally adhere to the program specified in the Career Training Foundation's Default Management Manual. Under our proposal, schools that exceed a 50 percent default rate would be required to undergo a biannual audit by either the Department or the guarantee agency. In either event, the determination of the school's continued eligibility to participate in the postsecondary financial aid loan programs should not be based upon the specific default rate but upon the schools' conformance or refusal to conform with a properly specified Default Management Plan.

Schools should be permitted to withhold that portion of Stafford and SLS loans which are intended for living expenses and to disburse those funds to the student on monthly or other regular basis. This delayed disbursement system builds upon the existing multiple disbursement system embodied in Title IV of the Higher Education Act and is intended to achieve the same purpose.

All schools, whether or not subject to a Default Management Plan, should be required to promptly notify guarantee agencies and lenders of any change in a student's status at the school. This is simply the first step in a part of a larger information network designed to prevent defaults from occurring at the onset of the repayment period.

A system of refund attribution should be devised so that any refunds due to a student are applied first to guaranteed loans and only thereafter to aid from any other sources; in the case of multiple loans, the amount of the refund should be applied first to loans bearing a higher interest rate and then to loans bearing lower interest rates.

Changes In The Administration Of Guaranteed Loans By Lenders, Services And Guarantee Agencies Are Needed

The first problem in this area which needs to be addressed is a structural one. The loan insurance coverage system needs to be changed from one which involves risk sharing to one which involves risk pooling.

Under the present system, risk sharing exists through the statutory provisions which limit the extent of insurance payments made by the Secretary when the amount of defaulted loans in an agency's portfolio reaches or exceeds specified levels. This has, demonstrably, proved ineffective in curtailing default. Lenders and guarantee agencies are well aware, that the incidence of default is a function of the populations served. The insurance penalty of the present system thus serves only to discourage the financial community from accepting loans from high risk students whether or not those students have the ability to benefit from the education which they seek to undertake and to distract both lenders and eligible institutions from the central task. That task is not to avoid making high risk loans but to avoid the incidence of default on high risk loans. This problem equally exists in the secondary as well as the primary lending market.

The solution lies not--as some have suggested--by increasing the level of risk sharing which the financial community would be required to bear; that would only exacerbate the existing situation. Rather, the solution lies in the creation of a system of risk pooling similar to that which exists in the automobile insurance programs in many states. Under this approach, high risk loans--measured on the basis of the student borrower's income--would be distributed (or assigned) evenly among eligible lenders and guarantee agencies of last resort. An identical program, in our judgment, needs to be established for the secondary market. By thus recognizing the real economic causes of default and spreading the risk of default among financial institutions and guarantee agencies, each financial institution will be better able to focus its effort upon preventing defaults on individual loans and rehabilitating loans which have gone into default. The system of risk pooling we have suggested thus shifts the focus from the avoidance of high risk loans to the avoidance of default. It thus preserves the fundamental integrity and purposes of the program.

There are a number of other specific and narrower measures relating to uniformity in administration and the exchange of information which should be taken to improve coordination among student borrowers, eligible institutions, lenders and guarantee agencies:

- A system of default confirmation reports, similar to the confirmation reports used in the Pell Grant program, should be established. This is essential because the Default Management Plan which we have proposed for schools critically requires the existence of accurate information. As a part of the default confirmation system, schools should be required within a specified period to confirm or correct the information submitted to it by the guarantee agency.

- A system under which guarantee agencies evaluate and certify loan servicers should be implemented. This will provide assurance to eligible institutions, lenders and guarantee agencies that the requisite paperwork and processing of loans is being performed properly, avoiding or at least reducing the incidence of loans which simply become "lost" in the system and thereby go into default.

- The system of notices given by lenders and guarantee agencies with respect to outstanding loans and loan transactions needs to be improved. For example, lenders should be required to give notice both to the guarantee agency, the school and the student whenever a loan is sold; lenders should similarly be required to notify both student and the eligible institution of receipt by it of a refund payment. Neither the school nor the student should be required to bear the cost of these notices. Along similar lines, guarantee agencies should be required to maintain a "hotline" for students and schools to locate loans and to access student loan databases.

- For schools which are under Default Management Plans, lending institutions should be empowered to delay the disbursement of checks to students when the guarantee agency or Departmental audit shows that the school is experiencing a high no-show rate, a high level of early student withdrawal and a high level of refund payments. In all cases, lenders should be empowered to issue loan checks in a manner which conforms with the school's disbursement and payment period.

- Lender and guarantee agencies should be required to develop and use a consistent set of program forms, policies and procedures. The bewildering variety of forms, policies and procedures which presently exists among lenders and especially guarantee agencies limits the ability of students to obtain, and indeed discourages them from applying for, the loan deferments provided for by law. The result is that significant numbers of loans are technically in default when, in actuality, they should be treated as deferred.

- Students should have the right to require that serial loans be placed with the same guarantee agency and, if sold in the secondary market, be sold to the same purchaser. Similarly, with respect to loans sold into the secondary market, students should be afforded the opportunity to combine, rather than consolidate, all existing loans.

The Department Needs To Take An Active Role In Default Management

The Department itself has a major role to play if the student default problem is to be brought under control. The first, and fundamental task is to develop a student loan database incorporating all state and national guarantee agencies which accurately and completely captures current information with respect to the status of loans, lenders and guarantee agencies. Until such a database is established, it will be (as it now is) impossible to assess the nature and extent of the default problem and to determine whether other and further measures are required to address it.

The second major task of the Department in a meaningful default reduction initiative is remarkably straight forward. The Department simply must commit the resources and energy necessary to see to it that the existing regulatory system is complied with by all participants, eligible institutions, lenders and guarantee agencies. For reasons which seem to us puzzling if not misguided, the Department has been extremely reluctant to undertake its existing responsibilities for the conduct of program reviews and even more reluctant (and in some cases seemingly unwilling), to use its existing power to initiate limitation, suspension or termination proceedings even when presented with plain evidence of abuse. To the extent that the incidence of default is a function of misconduct on the part of participants in the federal loan program, the Department has abundant power under the existing statutory and regulatory scheme to respond.

Under our proposed regulatory scheme, the Department would also have responsibility for approving the specifics of each Default Management Plan, for seeing to it that there is consistency in the Default Management Plan negotiated by guarantee agencies and schools subject to those plans and for seeing to it that the program review take place as required by the plans.

STATEMENT OF EMILY B. SWENSON, VICE PRESIDENT, CORPORATE AFFAIRS, CHILDREN'S TELEVISION WORKSHOP

Senator **Burdick**. Emily Swenson, Children's Workshop.

Ms. **Swenson**. Thank you, Mr. Chairman.

I am glad to be here today, and I want to start off by thanking you for your personal support in prior years for "Sesame Street." Your support has made it possible for us to continue the work that we have been doing, and it is the kind of work that is reported today in the front of USA Today. We thank you for your support.

I am here today to join others, Sharon Rockefeller, David Brugger, and Doug Bennet, to urge you to support the full authorized level of funding for the Corporation for Public Broadcasting [CPB] for fiscal year 1992.

I am also here to urge you to direct the Department of Education to commit more funds for children's television programming.

The Children's Television Workshop mission is to educate young people through the mass media. Funding from the Department of Education and the Corporation for Public Broadcasting is essential to us to enable us to do this work.

As you know, it has been often cited that children watch on the order of 23 hours of television per week. We can turn this boggling fact to our advantage, and that is the work that we try to do at the workshop.

By so doing, we can turn television into an ally rather than an obstacle to education.

Accessibility is one of television's greatest assets. It reaches the homes of the educationally and economically disadvantaged, where other programs often cannot reach.

It is also a sensible investment. Our programs cost on the order of pennies per viewer per episode, and seem a wise investment for the Federal Government.

Finally, and most importantly, children learn from television.

It is essential that the Department of Education take the lead role and fund deserving educational television projects. Some of you may recall that last year at this time, as CTW prepared to testify before this subcommittee, we had not yet heard from the Department of Education as to whether or not they would help us fund the second season of "Square One TV."

"Square One TV" is our television program that reaches on the order of 3 million children every week, teaching them mathematics, and addressing the kinds of problems that are reported to be widespread.

We find ourselves in the same situation today. We have yet to hear from the Department of Education as to the status of the funding for the third season of "Square One TV."

The Department of Education's indecision is particularly worrisome because we are in the process of developing another project which will address the problems of illiteracy in this country. Our efforts will need their firm and their timely commitment.

As has been mentioned before, CPB's strong support is equally important. We have, therefore, watched with some concern the struggle over spending in the public television community over the last year. We are particularly troubled by the consequences of the decision to set aside programming funds for minorities and independent producers.

The result has been a de facto reduction in funding for children's programming as well as other programming. Therefore, we urge you to support fully the appropriations to the CPB, as others have done already today.

Specifically, we urge you to support a specific principle that was in the authorizing legislation which states:

> It is in the public interest to encourage the development of programming that involves creative risks and that addresses the needs of unserved and underserved audiences, particularly children and minorities.

I just want to reiterate again what has been said before—public television is a wise and sensible investment, and from our point of view, that is particularly true as it applies to children.

Children have few alternatives, if any, to turn to for quality educational programming other than CPB.

PREPARED STATEMENT

So, to conclude, please support full funding for CPB, and direct the Department of Education to provide more financial resources in a timely way to support quality educational television.

Thank you, and I would be happy to answer any questions you may have.

[The statement follows:]

STATEMENT OF EMILY B. SWENSON

I am pleased to appear before you today. I am here to urge you to provide strong financial support for educational television. Specifically, I ask you to direct the Department of Education to commit more funds for national educational television programming that addresses major educational concerns in this country and to support the full authorized level of funding for the Corporation for Public Broadcasting for fiscal year 1992.

The Children's Television Workshop's mission is to educate young people through mass media. Funding from the Department of Education and the Corporation for Public Broadcasting is a crucial part of that effort. It has aided in the development of our two educational series for 8-12 year olds: SQUARE ONE TV and 3-2-1 CONTACT. Together they extend the educational day by providing an additional hour of math and science education. Through Community Service Grants, CPB also helps local public television stations pay about one-third of the yearly cost of producing SESAME STREET -- CTW's self-support revenues provide the rest.

CTW has spent more than 20 years addressing the educational needs of America's children. Television, which has often been viewed as an obstacle to education, can be an important ally. Quality educational programming can teach children the alphabet, numbers, reading, science and math. Studies further show that the right kind of programming motivates children, which in turn fosters interest in learning at home and in school.

At the Workshop, we are encouraged by the growing public concern about the well-being of children. America's youngest citizens are its poorest and neediest. Education is essential to their security and to ours. They are the ones who must keep the United States competitive in the future. They are also the ones who must support an aging population as productive members of America's 21st century workforce. They deserve the educational opportunities necessary for them to do so.

Education in this country is primarily the concern of parents, educators and local governments, which is as it should be. But we must not lose sight of the vital role the federal government must play. It is not solely the responsibility of the citizens of Iowa or Michigan or Tennessee to compete with the countries of Europe and Asia -- it is an issue that challenges us as a nation.

Quality television programming can make an important contribution to education at the national level, because television is accessible to all Americans. Most importantly it reaches the homes of the economically and educationally disadvantaged. Well over 90 percent of households with incomes below $5,000 have a working television set.

Using television to assist education at the national level is a sound and sensible investment. Today in this country there are 40 million "graduates" of SESAME STREET-- children who entered school better prepared for the rigors of the classroom. They received this benefit in large part because of federal support through the Department of Education which invested $30 million in SESAME STREET over the years. For a total federal tuition bill of 75 cents per student, 40 million children, so far, have learned the alphabet, counting and the social skills they need to thrive in preschool and kindergarten. What's more, the Department of Education investment continues to pay dividends. Every year over two million preschoolers join the ranks of the SESAME STREET alumni at no additional cost to the government.

It is essential that the Department of Education take the lead role in educational television projects at the national level and that it provide sustained, long-term funding for those endeavors which prove their worth.

Some of you may recall that last year as CTW prepared to testify before this subcommittee, we had not yet heard whether we would receive Department of Education funds for the second season of SQUARE ONE TV. We find ourselves in the same position this year with respect to the third season of SQUARE ONE TV, with no clear information that Department of Education funding will be available.

In the case of SQUARE ONE TV and 3-2-1 CONTACT we have been fortunate in that the National Science Foundation has stepped forward as the lead federal funder. NSF has understood the value of leveraging its investment through a long-term commitment to programming that can supplement learning in the critical disciplines of science and mathematics.

In the past, the Department of Education has demonstrated similar vision. SESAME STREET would not exist had the Department of Education not committed the necessary funds for the show's development. The same kind of commitment will soon be needed as we prepare to tackle another issue of concern to all of us-- the shocking level of illiteracy in the United States. An estimated 27 million people-- 15 percent of this nation's adult population-- lack basic literacy.

The struggle to become a literate nation begins with children. Only a broad-based national effort aimed at educating our young people can end the cycle of illiteracy. We think television can help.

The centerpiece of our effort will be a reading/writing series for home television broadcast. Our program will be targeted to children between the ages of six and nine-- a critical time in the development of reading and writing skills. We think we can motivate children, help them develop strategic approaches to reading and writing, and enhance their oral and written vocabularies.

To succeed we will need to apply the same principles of entertaining, educational television that have worked on our other series. We can help solve the literacy problem on the national level in a cost-effective fashion. But this project will only happen with clear and strong support from the Department of Education.

Parents are a child's first teacher, but television is a close second. Children spend over 23 hours of every week watching television. This statistic has been quoted so often as to lose its impact, so I ask you to think about it another way. Take a typical child. During the time he moves from kindergarten through elementary school, that child spends the equivalent of an entire year of his life watching television— that's 24 hours a day, seven days a week, 52 weeks a year staring at that television screen.

We can turn that boggling fact to our advantage. To do this we need to fund creative, innovative, exciting educational programming that will successfully compete with soap operas, old movies and quiz shows for our children's attention. It can be done. In its first season, for example, SQUARE ONE TV, reached over half of all households in America with children between the ages of six and eleven.

To continue this kind of success we urge you to support the full level of funds for the Corporation for Public Broadcasting for fiscal year 1992. While children find themselves with expanding viewing options, public television remains the only place they can turn to and learn on a regular basis.

In the past year we have watched the struggle over spending in the public broadcasting community with concern. One result of that struggle was more funds set aside for minorities and independent producers. Because of limited funds, this has resulted in a reduction of funding available for all other programming-- including children's programming. As an independent producer which reaches public broadcasting's largest minority audiences-- that shortage of funds hurts.

We urge you to support full appropriations to CPB. And we ask that you support a principle included in the authorizing legislation which is critical to the survival of effective educational programming; namely that "it is in the public interest to encourage the development of programming that involves creative risks and that addresses the needs of unserved and underserved audiences, particularly children and minorities."

Mr. Chairman, we understand the difficult budgeting decisions you face at a time when priorities are many and resources are clearly limited. We feel that public television is a wise and sensible investment since it is the only reliable source of quality educational programming in America. We hope Congress agrees and continues to fund public television at the level needed to serve our children.

Please support full funding for the Corporation for Public Broadcasting, and direct the Department of Education to provide more financial resources and extended commitment to support quality educational television.

Thank you.

Senator BURDICK. Thank you.

I have no questions, and I thank you very much.

Ms. SWENSON. Thank you.

CONCLUSION OF HEARINGS

Senator BURDICK. I would like to thank all the witnesses who have appeared before us with regard to the proposed fiscal year 1990 budget requests.

Today's testimony completes our hearings, and the subcommittee will now recess, subject to the call of the Chair.

[Whereupon, at 12:45 p.m., Friday, May 12, the hearings were concluded, and the subcommittee was recessed, subject to the call of the Chair.]

Material Submitted Subsequent to Conclusion of Hearings

[Clerk's Note.—Additional material was received by the subcommittee subsequent to conclusion of the hearings. The statements will be inserted in the record at this point.]

STATEMENT OF INDIAN AND NATIVE AMERICAN EMPLOYMENT AND TRAINING COALITION

The Native American programs authorized in Title IV and in Title II-B are the only programs that serve the employment and training needs of American Indian, Alaska Native and Native Hawaiian people throughout the entire United States.

Joblessness is the biggest single economic problem in virtually all Native American communities.

On Indian reservations, the latest official estimates published by the Bureau of Indian Affairs place the average jobless rate at 48% -- half of the available labor force. On some reservations it is as high as 80%.

The pressures of unemployment force thousands of our workers into the big cities and other off-reservation areas in search of work. Without the help which our JTPA programs can provide, they are often not able to compete in these labor markets where the positions now available demand higher and higher entry level skills.

Throughout the country Indian needs are rising while the resources are shrinking.

Nationally, the picture looks like this:

Since 1984, when JTPA started --

- The number of jobless Indian people in reservation areas has risen by 20%. (The government doesn't keep numbers on Indian unemployment in off-reservation areas.)
- Funding for the basic Indian program in Title IV of JTPA has been cut by 40% in constant dollar terms.

Since 1981 --

- The size of the Indian labor force, in reservation areas alone, has increased by 37%.
- The funding for all Indian employment and training programs handled by the Department of Labor has decreased by nearly 75% in constant dollars.

The issue is not just that our programs have more people to serve with less money. It is also one of the quality and cost of the services needed to help severely educationally and economically disadvantaged Indian and Native American workers get and keep skilled jobs in today's labor markets.

We ask that the Committee increase funding for the basic Indian Title IV JTPA program to at least $68.9 million, the amount available the year before JTPA started. (This request relates to the Native American programs line in the Federally Administered programs account that is part of the FY 1990 appropriations request for Training and Employment Services.)

We also ask that the Committee insure that the Indian set-aside authorized under the Title II-B JTPA Summer Youth program be at least $14.5 million, the amount available at the beginning of JTPA. (This is part of the Summer Youth program account.)

Turning to a related matter, we would also like to discuss the Department of Labor's FY 1990 request in the Program Administration account, the account that funds salaries and other administrative expenses for staff in DOL's Employment and Training Administration.

While the funds available to provide job training services to Indian people have shrunk radically over the years, the number of organizational units inside DOL that deal with our programs has multiplied.

We support a strong Indian office inside the Department of Labor which should be accountable to the Administration, the Congress and to Indian people. However, we question why the Department has so many different, unrelated offices, accountable to so many different people -- none of them Indian -- handling Indian JTPA administrative functions. Isn't this a waste of money, particularly at a time when the programs that actually provide employment and training services have been cut back again and again?

The Department of Labor has Grant Officers in three separate offices, controlling four separate functions with respect to Indian JTPA grants. There are two completely separate staff units in the Employment and Training Administration that conduct on-site monitoring of Indian grantees. Still another office controls the performance standards system that effectively determines what services we can and can't offer to our people.

All this bureaucracy inevitably leads to more paperwork, mostly paperwork which has nothing to do with our program services. Since JTPA started we have received over 160 "Bulletins," DOL instructions on how we should administer our programs. A recent Bulletin, telling us how to write our Program Year 1989 grant application was nearly an inch thick, weighed nearly two pounds and was very difficult to understand.

We would point out that Indian JTPA grantees are already accountable for our actions through two strong accountability systems, one involving performance standards and the other involving the audit system under the Single Audit Act.

Multiple layers of additional oversight imposed by all these different DOL offices is costing money which could be better spent in providing services to unemployed Indian people.

Funding History of Indian Job Training Programs: Selected Years

Program	FY 81	FY 83	PY 89	Request PY 90
Title III, CETA or Title IV, JTPA	80,975,000	68,915,000	58,996,000	58,996,000
Summer Youth	14,000,000	14,509,000	12,901,614	12,901,614
Title II-D, PSE	45,556,000	NA	NA	NA
Title VI, PSE	17,885,000	NA	NA	NA
CETA Year-Round Youth (IV-A)	17,500,000	3,840,000	NA	NA
Economic Stimulus or Title VII, CETA	6,700,000	4,600,000	NA	NA
TOTAL, ALL TITLES	$182,617,000	$91,864,000	$71,897,614	$71,897,614

STATEMENT OF JOHN T. JOYCE, PRESIDENT, INTERNATIONAL UNION OF BRICKLAYERS AND ALLIED CRAFTSMEN

Training, provides the best method for helping workers attain skill competencies and, at the same time, serve the demands of our economy for enhanced productivity and competitiveness. A leading example of training opportunity is the masonry industry. It currently provides direct and indirect employment to some half a million men and women in the United States. It is, to a considerable degree, a craft industry. Its competitiveness depends on the productivity of its craftsmen -- bricklayers, tile setters, stone and marble masons, plasterers, cement masons, terrazzo and mosaic mechanics and masonry restoration specialists -- and the productivity of those craftsmen depends on their training.

Historically, craft training in the masonry industry has occurred at the local level -- the result of partnerships between contractors and local unions. Those programs have served well in the past, and continue to be an asset. But they are no longer able to meet all of the industry's needs, or to take advantage of all of the industry's potential.

Studies and surveys prepared earlier in this decade showed that the industry not only could absorb and provide well-paying jobs for additional numbers of young men and women, over and above the numbers then in established industry training programs, but also that the productivity and competitiveness of the masonry industry required more intensive, comprehensive and technologically-advanced training than local programs could provide. These findings still hold.

In response to these conditions, contractors and employees in masonry developed and have begun to implement a plan to create a system of regional training centers including a national training center, to supplement and extend the work done in local training programs.

Under the plan, these centers will provide: pre-job training to apprentices, thus raising their competency levels and making them more productive from the moment they go to the job site; advanced and cross-branch training to journeymen; foremen training; training to both apprentices and journeymen in specialized craft areas; and training for instructors.

Masonry is also a service industry to the larger building industry and to a building market that produces houses, offices, schools, factories, churches and other structures. It is essential to both the building industry and market. Masonry is used in all segments of building, and in many structures is a predominant material and system. Improvements in training will, therefore, not only help the industry, but will also aid the entire building industry which produces all the structures our economy and our people require.

The commitment of contractors and employees in masonry to this plan for a system of regional/national training centers is strong and of long-standing. For the past six years, we have devoted significant amounts of resources to the plan and we intend to continue doing so. But it is apparent that the industry's efforts should be aided by a public commitment.

The masonry industry is an unusual industry because it does not contain large corporations which, through the accumulation of corporate resources, could on their own push this type of training program forward. Instead, contractors, who are nearly all small business people, and employees, are providing support, but more is necessary.

It is our recommendation that the Congress, make funds available to help construct and operate the regional/national training center system for masonry craft training.

The building industry has a need for more and better trained craftsmen. It is imperative that young American workers have expanded opportunities to learn trades and skills that will enable them to contribute to the needs of the next century.

STATEMENT OF PHILLIP V. ALEXIS, CONFEDERATED HISTORIC TRIBES, INC.

MICHIGAN INDIAN ECONOMIC DEVELOPMENT

Michigan Indian Economic Development planning at the state level has its roots firmly based in law. In 1985 the Michigan Governor's office, Commission on Indian Affairs, and the Office of the Attorney General concluded a three tier definition establishing criteria to determine whom an Indian is from a state perspective. The state definition includes federally acknowledged tribes, state historic tribes (treaty tribes at time of state charter in 1837), and recognition of federal tribal members from other states whom have established residency in Michigan.

The state definition process and follow-up activity by the Michigan Commission on Indian Affairs, Michigan Department of Commerce, and the Governor's office brought together Indian leadership from each of the three categories covered by the definition and directly representing Michigan Indian tribal governments and off-reservation communities. Development of tribal economies, Indian Economic Development, became the priority for joint action by Indian Tribes and the State of Michigan. These priorities were developed in specific phases.

PHASE I: Federal Tribal Economic Empowerment - 1986-88

In 1986 a new organization, the American Indian Business Development Consortium (AIBDC), made up of representatives of all tribal governments and all off-reservation leadership created a "Michigan Indian Seven Point Plan" to address deficiencies in tribal economies at the state level. According to plan the AIBDC and state would first address the needs of federally recognized tribes through joint state and federal economic development program planning. Michigan Indian economic development planning in the first phase has provided Michigan federally recognized tribes with $425,000 in each of the past two years via the Department of Interior, Bureau of Indian Affairs (BIA) budget process to implement the Michigan Indian Seven Point Plan.

PHASE II: State Historic Tribal Economic Empowerment - 1989-90

Now Phase II of the Michigan Indian Economic Development activity focuses upon the state historic tribes. The state historic tribes are recognized by the State of Michigan and while they were parties to treaties with the federal government, they are not federally recognized. Therefore, the state historic tribes are not eligible for the special programs and assistance provided to federally recognized tribes through the Bureau of Indian Affairs. We are therefore seeking an add-on of $290,000 to the FY 1990 appropriation of the Administration for Native Americans. Using the Michigan Indian Seven Point Plan, the State of Michigan and leadership from the state historic tribal governments have cooperated to create a model approach to creation of community based economic development activity in Michigan. First, state historic tribes organized themselves into a state non-profit called the Confederated Historic Tribes of Michigan (CHT). State of Michigan funding via the Michigan Commission on Indian Affairs supports core staff. The Confederated Historic Tribes, Inc., directly represents the interests of the Huron Band of Potawatomi, the Pokagon Band of Potawatomi, the Burt Lake Band of Ottawa, and the Lac Vieux Desert Band of Lake Superior Chippewa at both the state and federal level. A formal council structure, staff development, elected leadership, and planning for CHT have been concluded. The CHT now requests the assistance of the U.S. Department of Health and Human Services (HHS), Administration for Native Americans (ANA) for Phase II Michigan Indian Economic Development activity.

The Confederated Historic Tribes, the state of Michigan, and the Native American Institute at Michigan State University have cooperated to create plans for development of the Michigan Indian Center For Off-Reservation Economic Development. This state/ historic tribal connection located at Lansing provides Michigan Historic Tribes with access to the Michigan Department of Commerce and is supported by both state and local funding. The strength of the Center for Off-Reservation Economic Development (CORE Development Project) lies in its bringing together of historic tribes, the State of Michigan resources and an organized body of existing and successful Indian business persons to initiate development of historic tribal economies using the Michigan Indian Seven Point Plan already in use by state and federal agencies.

As a preparatory activity the Michigan Department of Commerce and the Michigan Commission on Indian Affairs cooperatively funded and completed a comprehensive review of Indian law and court cases relating to Indian Business Development to create a common knowledge of court tested avenues to establishing Indian business and tribal economic development. In Michigan this written document is called the Michigan Indian Deskbook. Thus, historic tribes have been organized, a legal base for development has been completed, and the CHT now intends to blend successful Indian business leadership, state historic tribal government authority, and resources from both state and federal levels to create what could be the nations first successful state and historic tribal business development cooperative. Completion of Phase II of the Michigan Indian Economic Development Plan will result in new tribally controlled Indian business led by experienced American Indian, and mainstream, business persons.

In less than 24 months the Confederated Historic Tribal business development initiatives will be supported by the first American Indian BIDCO (Business Industrial Development Corporation) successfully created in the nation. The Michigan Indian BIDCO is currently being created by the State of Michigan, and Michigan Indian tribes, utilizing resources already appropriated at the federal and state level. The Michigan Strategic Fund through the Michigan Department of Commerce has agreed to cooperatively establish the Michigan Indian BIDCO (a revolving loan, business development institution serving all Michigan Indian business activity).

With the support of the State of Michigan, the Michigan Department of Commerce, and Michigan Indian Historic Tribal governments, the Confederated Historic Tribes (CHT) requests a $290,000 add-on to the HHS-ANA budget to complete Phase II of the Michigan Indian Economic Development Plan. The $290,000 request will allow for enhancement of an existing enterprise zone plan already funded in S.W. Michigan at Benton Harbor and create other off-reservation business development sites in the state of Michigan. Joint ventures between federally acknowledged tribes and historic tribes will be encouraged at these sites and state and private investment will be blended to create new jobs for Indian tribes in Michigan.

SITE PLANNING AND EVALUATION:

A. SITE PLANNING AND EVALUATION

Business must be assured that the needs of industry will be met if they locate on or relocate near to an Indian reservation. This requires an inventory of not only reservation resources and land base, but an inventory of the physical infrastructure required by various industries. Also, it is necessary to identify lands which could be acquired to promote Indian economic development both on or near reservations in Michigan.

Site Planning and Evaluation Components

1. Inventory of the resources which are located on historic tribal reservations in Michigan. This inventory would include timber resources, aquatic resources and suitability of land base for specific industry activity. Waste disposal and environmental considerations will also be examined as a part of this inventory. In addition, soil types and possible agricultural businesses will be examined.

   Inventory of the physical infrastructure of Indian communities which will allow Indian tribes and organizations the ability to compete for new business ventures and the relocation of existing businesses. The inventory must include an examination of energy, supplies, roads, sewers , and water supplies. In addition a profile of supportive community resources must be compiled to assure businesses that the personal needs of their employees will be met. This profile will include the quality of local schools and educational programs, cultural and recreational entertainment, local consumer index information, and general highlights of the surrounding community to attract prospective businesses.

COST FOR INVENTORY OF RESOURCES AND PHYSICAL INFRASTRUCTURE	$30,000

2. The identification of lands which can be utilized for Indian economic development will also be identified. The lands which are adjacent to existing reservations, as well as lands which have economic potential, will be identified in cooperation with the Michigan Department of Commerce and mechanisms for purchase will be explored.

   Specific regions of Michigan have very strong business climates. These regions are located in the southern tier of the state. Lands in these regions, as well as businesses, will be identified for purchase by Indian tribes for development purposes. The cities and regions to be surveyed are: Lansing, Grand Rapids, Detroit, Flint, Benton Harbor, and the I-75 corridor. The identification process will make a special effort to locate land which could be used to promote a joint venture between Indian tribes and urban Indian populations.

COST FOR IDENTIFICATION OF LANDS	$35,000
TOTAL EXPENDITURES FOR SITE PLANNING AND EVALUATION	$65,000

B. POPULATION AND LABOR DEMOGRAPHICS - DATA BASE AND COMPUTER CAPABILITY

Long term economic development requires knowledge of the availability and skills of the Indian populations. An inventory of Indian and non-Indian skills and experience is necessary to assure a favorable business climate for business development. In addition, there is also a need to create a data base and have the ability to communicate business information rapidly. Resources must be matched with the needs of prospective businesses in the shortest possible time. The creation of computer communications and a data base will allow Michigan Indian tribes to compete with other sectors of the economy attempting to attract industrial development.

Population and Labor Demographics - Data Base Computer Capability

1. Inventory of the skilled and unskilled labor force in 4 regions of Michigan. This inventory will assess Indian and non-Indian skills and demographics since many businesses do currently and will employ non-Indians in some capacities.

COST OF INVENTORY OF LABOR FORCE	$25,000

2. The development of a data base is crucial to sustaining business start-up and growth. The demographic and site planning and evaluation information must be made available to businesses on a moment's notice. This will spur development by making tribes competitive with municipalities and others attempting to recruit industrial development.

COST OF SOFTWARE AND DATA INPUT	$20,000
TOTAL EXPENDITURES FOR POPULATION AND LABOR DEMOGRAPHICS--DATA BASE AND COMPUTER CAPABILITY	$45,000

C. MANAGEMENT TRAINING

Few American Indians are well educated in business management. Indian Business failure has too often been a direct result of the lack of substantive knowledge of the mechanics of business operations and objectives. Indians must be trained to perform supervisory and management duties in the workplace.

Management Training Components

1. Four or more new businesses will be created. Each of these businesses will enroll managers in intensive training session on Production Management for Profit. Costs associated with these training sessions will include meals and stipends for enrollees, and the cost of hiring trainers. Topics to be covered include:

   - Contracts and contract management
   - Making hard line business decisions
   - Personnel management/hiring and policies
   - Marketing and promotion
   - Quality and production control
   - Purchasing and inventory
   - Scheduling workers
   - Production Schedules

- Invoicing and billing
- Financing and expansion

COST FOR CONDUCTING MANAGEMENT TRAINING SESSIONS	$30,000

2. There is a need to make certain that tribal leaders and decision makers are fully aware of business initiatives and principles. For this reason, a special workshop on business principles will be designed and implemented. This workshop will cover the legal responsibilities of tribal leaders, general business principles, financial management, and making "hard line" business decisions.

COST FOR TRIBAL TRAINING	$15,000
TOTAL EXPENDITURES FOR MANAGEMENT TRAINING	$45,000

II.

A. INDIAN OFF-RESERVATION BUSINESS PLANNING AND DEVELOPMENT

Currently, few procurement contracts are let to Indian owned businesses. Technical assistance to businesses is crucial to increase the letting of set-aside contracts and to promote joint ventures between Indian entrepreneurs and reservations. Private sector business planning and development create viable, profitable partnerships among reservations, urban Indian organizations and Indian business people.

Private Sector Business Planning and Development Components

1. Workshops on procurement contracting with local, state, and federal agencies will be conducted for Indian businesses and interested tribes and organizations. This will allow tribes to develop an in-depth understanding of the procurement process and enhance the opportunities which exist for Indian business participation.

COST OF WORKSHOPS	$10,000

2. Seminars and workshops for Indian businesses will be conducted to focus on the economic development potential that is based on federal Indian law. Training will include workshops which use "Doing Business With Michigan Indian Tribes". The outcome of these seminars and workshops will be the creation and promotion of tribal joint ventures.

COST OF FOUR REGIONAL TRAINING SESSIONS	$25,000
TOTAL EXPENDITURES FOR PRIVATE SECTOR BUSINESS PLANNING AND DEVELOPMENT	$35,000

B. MICHIGAN INDIAN ECONOMIC DEVELOPMENT STRATEGIES

The design of the Michigan Indian economic development strategy will require sophisticated financial advice. The design of tribal development strategies will be tailored to investment capabilities, resources and capital needs of each of the tribes in Michigan. Acquisition and formation of new businesses will be completed in conjunction with formulating economic development strategies. At least four American Indian businesses will be created as a result of the activities which follow.

Michigan Indian Economic Development Strategy Components

1. Business plans will be developed for American Indian tribes and communities in Michigan. At least four of these plans will be developed during the first 12 months of the project.

COST TO DEVELOP BUSINESS PLANS $25,000

2. Feasibility studies of potential business ventures must be undertaken to decrease the risk of failure. Every effort must be made to ensure viable investments and business initiatives. For this reason, feasibility studies will be conducted on potential business opportunities for Indian tribes. These studies will support the continued growth and diversification of tribal economies.

COST OF FEASIBILITY STUDIES $25,000

3. Tailored marketing plans will be developed for four or more Indian businesses. Again, this activity goes hand in hand with advertising and promotion, but must be considered separately due to the time that is required to develop a long-term marketing plan.

COST TO DEVELOP FOUR OR MORE MARKETING PLANS $20,000

4. One of the most critical areas of business formation is financial packaging. Assistance in this area is necessary if "deal-driven" businesses are to be brought on line. If a market exists, and a supplier stands ready to fill an existing void, financing can be arranged to culminate the deal. Expertise in this area is crucial to Indian businesses since few and communities have personnel with extensive banking experience. Financial expertise will be used to package at least four Indian businesses which will be created as a part of American Indian Business Development Consortium efforts in the next 12 months.

COST FOR FOUR OR MORE FINANCIAL PACKAGES $30,000

TOTAL EXPENDITURES FOR MICHIGAN INDIAN ECONOMIC DEVELOPMENT STRATEGIES $100,000

The Confederated Historic Tribes will serve as fiduciary for the project. State of Michigan funding will provide for core staff costs of the CHT. The ANA-HHS funding will allow creation of a state historic tribal strategic plan designed to increase access to state of Michigan funding and private investment in Michigan Indian business.

The State of Michigan, its Governor James J. Blanchard, and the Director of the Michigan Department of Commerce Doug Ross urge your support in the model off-reservation Historic Tribal business development initiative created by the state of Michigan and Michigan Indian tribal leaders to develop self-sustaining, self-reliant, Indian owned and operated business to employ Michigan off-reservation historic tribal Indians.

Older Americans Act Initiatives

In addition, the CHT of Michigan also request an earmark of $75,000 from the Older Americans Act budget to develop a model seniors project in Michigan.

The State of Michigan has completed a statewide assessment of American Indian seniors. This survey will allow for specific local Indian senior programs to meet the demonstrated needs of Michigan Indian Historic Tribal seniors.

The Older Americans Act funding at the State level is coordinated by the Office of Services to the Aging. The $75,000 request would enable staff to be directly coordinated with the State Office on Aging and to underwrite costs associated with service delivery directly to the Confederated Historic Tribes of Michigan.

TOTAL PROJECT COST $75,000

STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE INDUSTRY COUNCILS

The National Association of Private Industry Councils (NAPIC) appreciate the opportunity to submit this statement on Fiscal Year 1990 appropriations for several targeted job training, education and placement programs which are under the purview of this Subcommittee.

NAPIC is the only national organization representing and serving the nation's network of private industry councils (PICs). Our membership includes some 390 PICs.

Our purpose in submitting this statement is: first, to encourage, at a minimum, level funding plus inflation for the job training and placement programs under Functions 500 and 600; second, to support an increase above inflation for Title II-A, the core targeted program under the Job Training Partnership Act (JTPA); and, third, to encourage adequate start-up funding levels for the new dislocated worker program under Title III of JTPA and the JOBS program for welfare recipients under Title II of the Family Support Act of 1988.

Congress is aware of the changing skill requirements of the workplace, the changing demographics of the nation, and the possible negative consequence of the intersection of these variables. We will not add to the studies and testimony before the Congress on this subject. Suffice it to say that American business is concerned that the nation faces a gap between the job opportuni- ties of the next decade and the qualifications of available workers. Employers already are drawing entry level workers from a population pool that all too often is deficient in terms of educational achievement and training.

Unfortunately, PICs are finding that federal investments in education and training are declining in real dollars even as the demand and need for these services is growing.

PICs are particularly distressed by reductions in spending on targeted federal programs that focus on making the promise of a job for everyone who wants one into a reality. We are referring to programs designed for economically disadvantaged youth and adults, dislocated workers and welfare recipients. Of major importance in this regard is the Job Training Partnership Act, especially Title II-A and Title III, the new Economic Dislocation and Worker Adjustment Assistance (EDWAA) program. Also of key importance to local job training strategies will be the new Job Opportunities and Basic Skills (JOBS) program under the Family Support Act of 1988. Funding for these programs needs to be increased.

Federal investments in workforce preparation for the disadvantaged have declined consistently over the past decade. For example, in 1983, JTPA grants to states and local service delivery areas for training economically disadvantaged youth and adults, were sufficient to serve on average about five (5) percent of the eligible population. Now, because of reductions in appropriations and the effects of inflation, JTPA program dollars are only able to accomplish 75 percent of what they could in 1983. Yet, in today's tight labor markets, JTPA must increasingly focus on harder to serve individuals, further raising costs and reducing the numbers served. This imbalance can only be rectified through increased funding.

Congress has increased the role of the PIC in a variety of related job training legislation. As of July 1, PICs will plan and oversee dislocated worker programs under Title III of JTPA. PICs are to review and comment on job training contracts under the new welfare legislation, and will administer the authorized education and training programs in many communities. PICs have joint planning responsibilities under the Perkins Vocational Education Act and the Wagner-Peyser employment service program. To sustain and build the PIC as an effective advocate in these policy areas requires adequate funding for JTPA. The PIC needs to remain a viable training and compensatory education provider if it is to contribute to successfully integrating the varied federal, state and local job training investments that are available in every community.

PICs are working to implement the JTPA dislocated worker program at this time and are key partners in many states in trying to ensure that the JOBS program really has an employment pay-off for welfare recipients. But these programs must be funded at a level that gives them a chance to deliver on their legislated goals. We are concerned that the President's budget request, $400 million for dislocated workers and $350 million for JOBS, may be too small for starting new national efforts. We hope that some additional funds might be added to both of these programs so that they have a true opportunity to deliver on the promise Congress and the American people have placed in them.

Together with nine other national organizations, representing a coalition of governors, mayors, state legislatures, counties, cities, employment security, public welfare and business, we also are requesting at least enough funds to keep up with current service levels in several other core programs in targeted job training: the public employment service under the Wagner-Peyser Act; the Carl Perkins Vocational Education Act; the Adult Education Act; the Older Americans Community Service Employment Act; Food Stamp employment and training assistance; training funds for the homeless under the Stuart B. McKinney Act; Trade Adjustment Assistance training and relocation activities; and the federal-state unemployment insurance system; as well as adequate funding for the transitional Work Incentive (WIN) program; and administrative support for the Targeted Jobs Tax Credit program.

This is the first time that business leaders and elected officials have felt compelled to join in supporting adequate funding for federal job training and related efforts. We are convinced that all of us must continue to work together on grounds of both social equity and economic necessity.

In closing, we encourage you to ensure adequate appropriations levels for the programs we have noted. At a minimum, these programs need sufficient funding to maintain current levels of services at the local level. Furthermore, the nation will have to expand certain of these services in the coming years. We recognize the difficult decisions the Congress and Administration face on the deficit. At the same time, we believe the long term need is for increased spending in those areas of the federal budget that address the education, training, and employment needs of low income families, dislocated workers and other target populations.

STATEMENT OF THE AMERICAN DENTAL TRADE ASSOCIATION

We are pleased to have this opportunity to provide this testimony with respect to your fiscal year 1990 appropriations for the Department of Labor. Our concern is a very specific one. We are urging the Committee to remove from appropriations for 1990 all funds to support the implementation and enforcement of the OSHA "Right to Know"--hazard communication regulations, at least to the extent that specific products are already being regulated by other federal regulatory agencies.

The American Dental Trade Association is a voluntary nonprofit organization founded in 1882. Among its members are 75 manufacturer companies and 70 distributor/retailer companies. It is estimated that ADTA's manufacturer members account for 65% of the total sales of the dental industry at the manufacturer level, and that the Association's distributor/retailer members account for 55% of the total industry sales at that level.

The products manufactured and distributed by members of the ADTA are used by and sold only to the dental profession and the dental laboratory industry. While some divisions or subsidiaries of member companies manufacture products sold to the general public, these products are not within the scope of the Association's interest or activities.

Products manufactured by members of the American Dental Trade Association include dental equipment, precious metals and other alloys used in dentistry, artificial teeth and so-called "sundry merchandise" such as impression materials, filling materials, denture base materials and literally thousands of others.

All of these are products which since 1976 have been subject to detailed regulation as medical devices under the auspices of the Food and Drug Administration. When the Department of Labor's Occupational Safety and Health Administration first developed its hazard communication regulations, it excluded these regulations from applying to the dental industry (and the medical device and drug industries generally) by explicit exemptions based on Standard Industrial Classification code numbers. However, the history of OSHA's activity in this area in the last two years has been vexing, confusing and extremely burdensome, to say the least.

(1) In 1983 OSHA implemented "right to know" regulations and excluded many industries, including the dental industry;

(2) In 1985-86 OSHA lost a lawsuit raised by a labor union and was ordered to expand the scope of the regulations;

(3) In August, 1987, OSHA, under pressure from the Courts to implement the above decision, adopted new final regulations which expanded the right to know regulations to apply to a greatly increased number of industries, including among others, the dental industry;

4) These new regulations had staggered effectiveness dates, but had to be met by all facets of industry by May 23, 1988--however, prior to that time there was a court order to stay enforcement of the new regulations until an appeal of the underlying labor union lawsuit was settled;

(5) Subsequently, the court-ordered stay was lifted, however, enforcement of a portion of the regulations had been withheld due to OMB objections.

With confusion growing among our members and among the dental profession, on April 26, 1988, ADTA filed a formal request for any advisory opinion focusing primarily on the following issue:

- Whether FDA-regulated medical devices which do not meet the definition of an article are exempt entirely from the Hazard Communication Section?

To date, we have received no response to that request. In December, 1988, OSHA held two weeks of public hearings where they received testimony about proposed modifications to the regulations. At that point the regulations were partially in force, with enforcement of a portion of the regulations having been barred by the Office of Management and Budget. The proposed modifications to the regulations had been developed to satisfy OMB's objections. One important change proposed then by OSHA was to exempt most FDA-regulated drugs, because in their opinion, the FDA-required labeling provides information comparable to that required by the OSHA regulations. During the hearings we raised the issue of our advisory opinion request, and noted that FDA-regulated devices are subject to labeling requirements similar to drugs. We were informed that the agency would be responding to our request in the near future.

That was the general status last December, but since that time, the Court has ruled that OMB's "embargo" on enforcement of the regulations is improper. Therefore, the full OSHA regulations are in force at present. The agency is still involved in reviewing its proposed modifications to the rules, however, since those rule changes were developed to "satisfy" OMB, and the OMB involvement now has been ruled improper by the courts, the premise or incentive for OSHA to make these modifications to the rules has been removed. OSHA is in the very unusual position of having a clear field to enforce the regulations as they originally wanted, but now have proposed changes in rulemaking to soften those rules. Under these circumstances, we believe it is accurate to assume that it is unlikely that any changes to the regulations will come very promptly.

We recite this entire chronology to demonstrate how inconsistent OSHA's policy has been. This is troubling for everyone, but particularly for industries such as ours that are already subject to comprehensive federal regulation by FDA. The agency has ignored claims of duplicative, possibly conflicting regulations, and now appears to be moving "full-speed ahead" on enforcement plans. Thus, we must bring to the Congress the request for action to avoid unnecessary, duplicative overregulation that costs both the government and our industry in enforcement and compliance efforts. The most effective step to bring this situation under control would be elimination of funding to the agency for any enforcement of these regulations, or at least for any enforcement against industries/products already regulated by FDA or other agencies.

Thank you for your consideration of our request. We would be pleased to respond to any questions for the record.

STATEMENT OF RICHARD G. FREEMAN, PRESIDENT, INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, INC.

Mr. Chairman, members of the Subcommittee, my name is Dick Freeman. I am President of the Interstate Conference of Employment Security Agencies, Inc. (ICESA) and Director of the Iowa Department of Employment Services. I am joined today by Bob Martin of the U.S. Chamber of Commerce and Jim Ellenberger of the AFL-CIO in a unique partnership to present our views concerning FY 1990 appropriations for Employment Security programs.

Over the last seven budget years, the employment security system has suffered severe budget reductions, which have resulted in fewer locations where unemployment claims can be filed and employment services obtained, as well as a reduction in the types of employment services offered. Employers, workers and administrators are all concerned about this decline in services.

As you know, federal unemployment taxes are imposed on employers to pay for the normal administration of unemployment insurance and employment service programs. These are not general revenue funds, and their use is legislatively restricted to the purpose for which they are imposed. In FY 1989, the Department of Labor estimates that $930 million (M) more will be collected under the Federal Unemployment Tax Act (FUTA) for employment security administration than will be expended. In FY 1990 the Administration estimates FUTA revenues at $3.65 billion (B) but only requests $2.69B to administer the employment security system--$960M less than FUTA revenues. It is difficult for employers, workers and administrators to understand why the employment security system must face continued reductions when the federal government expects to collect $960M more in federal unemployment taxes in FY 1990 than the Administration plans to spend for employment security programs.

There may always be disagreements between the states and the Secretary of Labor about the amount of funds necessary to administer properly and efficiently unemployment compensation laws and provide public employment services; however, the level of federal funds has reached the point that many states have been forced to supplement federal funds with state funds in order to operate unemployment insurance (UI), employment service (ES) and labor market information (LMI) programs. Some states have appropriated state general funds; a growing number are enacting state payroll taxes for UI and ES administration. Employers and, ultimately, the public are paying twice for employment security services in these states. Mr. Chairman, in Iowa, employers will pay an additional $5.4M in support of our Job Service offices as a result of a special surtax. This is in spite of the fact that they have already been taxed at a level adequate enough to support our operations.

ICESA recently surveyed states to determine how many are using state funds to supplement federal funds for employment security programs. The survey showed that 35 states expect to spend approximately $140M in state funds for employment security programs in FY 1989. This is a very recent phenomenon in the 53-year history of this country's employment security system. The taxing authority and responsibility for funding rest at the federal level. Unless these arrangements are altered, states should not be forced to raise additional revenues in order to maintain services for which the federal government has already imposed a payroll tax.

States know that they are, in effect, letting the federal government off the hook by providing state funds to keep programs operating at a level that meets minimum state needs. The alternative is to operate an employment security system that is simply not acceptable to the employers and workers of the state.

The following outline describes in more detail the financial situation of employment security programs.

Employment Service

Once again, Mr. Chairman, thm Administration's budget request would further reduce the ability of State Employment Service Agencies to meet the employment needs of our nation's jobseekers and employers. Specifically, it would reduce the 1989 program year funding level ($763.8M) by nearly $72M. The impact of such a reduction would be devastating: offices would be closed in urban and especially rural areas; staff further reduced; and services curtailed.

Last year, the Congress provided supplemental funds to avert office closings and stabilize the system. We request your support for a level of funding in Program Year 1990 that will keep offices open, shore-up essential services and begin investment in automation.

We request your support for funding that will replace, on an incremental basis, a portion of employment service staff that have been cut over the past seven years. The current staff level of approximately 15,000, less than half the 1982 level, is totally inadequate to meet the need for services. Additional resources this year and in succeeding years would permit the states to reach a national staffing level of 20,000; an increase of nearly 5,000 from our present level.

In addition, the system desperately needs earmarked funds to improve its capacity to serve jobseekers and employers through automation. A recent survey of our members clearly reveals the severity of this situation. For example, 21 percent of all local ES offices are either marginally automated or have no capability in this area whatsoever and 9 percent of all local offices are without terminals for use by Employment Service interviewers. The system needs these earmarked funds to improve services through automation. We request $25M in Program Year 1990 to begin this process.

Unemployment Insurance

The Administration's request for unemployment insurance operations would provide for the increased cost of doing business but would reduce base/permanent staffing levels by over 1,000 jobs. The great strength of the unemployment insurance system is its ability to expand and contract in direct response to the business cycle. There is a minimum level, however, below which the system does not retain enough experienced staff from which to expand when unemployment goes up. We believe that many states are at or below that level now.

We urge you to reject the Administration's request to cut UI base/permanent staff by over 1,000 jobs. This cut is not justified by lower levels of unemployment (insured unemployment is expected to remain at the same level in FY 1990 as it is in FY 1989). It would merely replace trained workers, which the system badly needs to retain, with lower paid temporary staff.

Labor Market Information

Labor market information is an increasingly important component of the employment security system, which is funded through a variety of programs. Funds for gathering key occupational and employment data have been curtailed over the last several years. We request that FY 1990 funding for labor market information under JTPA Title IV, D be increased from the President's request of $4.4M to $7.5M, in order to produce adequate occupational data for substate areas.

We also support the Administration's budget request for the Bureau of Labor Statistics ($242.3M for FY 1990).

Conclusion

Mr. Chairman, thank you for this opportunity to present our views. We would be pleased to respond to any questions that you or other members of the Subcommittee may have concerning these programs.

STATEMENT OF C. RONALD TILLEY, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, COLUMBIA GAS DISTRIBUTION CO.'S

I appreciate the opportunity to provide a written statement for the record in support of adequate funding for the Low-Income Home Energy Assistance Program (LIHEAP).

Columbia Gas' distribution companies consist of Columbia Gas of Kentucky, Columbia Gas of Maryland, Columbia Gas of New York, Columbia Gas of Ohio, Columbia Gas of Pennsylvania and Commonwealth Gas Services and Lynchburg Gas (both in Virginia). Collectively, these Columbia companies provide natural gas service to more than 1.7 million consumers.

Columbia Gas is acutely aware of our consumers' energy needs, especially our low-income consumers. Our commitment to meeting their needs has not wavered. We have long supported federal energy assistance programs such as LIHEAP and the Department of Energy weatherization program.

Our own experience in working with customers has shown that LIHEAP is a vital program that greatly assists low-income consumers in paying a portion of their energy bills. For the most part, customers receiving LIHEAP are the single heads of households and working poor who need and deserve federal energy assistance.

Columbia's customers have been shielded from the serious impact of past LIHEAP funding cuts because of our successful efforts to stabilize natural gas costs coupled with our consecutive winters of warmer-than-normal weather.

However, natural gas prices have already flattened out and could edge up slightly in the near future. This factor, coupled with the threat of a colder than normal winter at any time, could create a crisis situation for low-income consumers.

Even more critical is the fact that due to the funding cuts of recent years, less or no LIHEAP money is being used for weatherization. Unfortunately, low-income households continue to live in substandard, mostly rental housing that often wastes energy and results in higher energy costs to people who can least afford them. Already our low-income customers spend 15% of their incomes on heating compared to about 5% for an average income household. The bottom line is that funding cuts reduce the chance for a long-term solution to this national crisis affecting millions of families.

In order to supplement federal funding efforts, we at Columbia have developed several innovative and effective assistance programs to aid low-income consumers because we do not believe the federal government should bear the entire burden. Indeed, business and local communities must share in solutions directed toward poverty. This we are doing -- with financial support as well as with innovative programs and human resources.

COLUMBIA OFFERS PROGRAMS TO ASSIST LOW-INCOME CONSUMERS

For example, at Columbia we offer a fuel fund program in which our stockholders match from $1 to $2 for every $2 donated by our consumers. In the past six years, this program has generated $1.4 million in emergency assistance to low-income consumers in our service area.

Another program is our Columbia/Citizens Energy Program. We work closely with the not-for-profit Citizens Energy Corp. in implementing a fuel fund program that utilizes spot market priced natural gas supplies. This program has generated $7.6 million in energy assistance funds for Columbia's low-income consumers since 1982.

At Columbia Gas, we have on our staff professional social workers to work with some of our low-income consumers who are attempting to become more self-sufficient. These employees link up needy families with as many community service resources as these people are eligible for, not only energy assistance but for other types of assistance as well.

Columbia actively supports weatherization programs for the low-income household. For example, in Ohio during the past two years, we have leveraged about $2 million of our stockholder funds against Ohio Department of Development oil overcharge funds to weatherize more than 10,000 low-income homes. This effective leveraging of funds will be in jeopardy as the oil overcharge funds run out.

ALL ENERGY CONSUMERS AFFECTED BY LIHEAP FUNDING CUTS

Adequate LIHEAP funding is more than just a low-income consumer issue, because adequate funding of LIHEAP has a significant affect on keeping utility rates stable for all consumers.

Paying the full amount of their utility bills is not possible for many low-income consumers who do not receive energy assistance. With mandated and voluntary moratoria on utility service terminations in most states during the winter months, these consumers continue to receive gas service. Keeping in mind the fact that heat is a necessity, we also attempt to work out manageable payment plans for these consumers in addition to our other programs.

If these efforts are not successful, the cost of providing gas service without payment is ultimately considered part of a utility's cost of service and later becomes a burden that is borne by all utility consumers. Already, the "hidden tax" has increased to the point that 80% of our customers that can manage to pay bills regularly question if these costs are justified.

In the past, many states have supplemented their LIHEAP programs with oil overcharge monies in order to continue to help the maximum number of low-income consumers. However, the oil overcharge funds are diminishing quickly. A National Consumer Law Center study shows that 95% of these funds have already been allocated.

Together, the private and public sector initiatives to help these consumers is still not enough. Quite frankly, the need is too great -- the gap between the cost of energy and what low-income consumers can pay is too great.

CONCLUSION

Certainly, both the private and public sector must be prudent managers of spending. However, there is a limit as to what assistance the state and local governments and businesses can provide in order to supplement the federal budget cuts of the LIHEAP program. We believe LIHEAP has already taken more than its share of cuts compared to other federally funded programs.

Assistance is needed for the low-income consumer who is struggling to make ends meet. I respectfully urge the Subcommittee to support our recommendation to fund LIHEAP at the level of $1.4 billion for FY 1990.

STATEMENT OF DAVID C. CARIS, GOVERNMENTAL AFFAIRS COORDINATOR, IOWA-ILLINOIS GAS & ELECTRIC CO.

Iowa-Illinois Gas and Electric Company (Iowa-Illinois) opposes the Bush administration's proposal to cut the Low-Income Home Energy Assistance Program (LIHEAP) funding from $1.383 billion in the current fiscal year to $1.1 billion for fiscal year 1990. In addition, Iowa-Illinois is asking Congress to increase next year's appropriation to $1.44 billion to compensate for inflation.

The LIHEAP program provides direct financial assistance to people who would otherwise be unable to maintain utility services. Our industry supports efforts to reduce the deficit, but believes it can and should be done without jeopardizing the LIHEAP program and its beneficiaries.

In the areas Iowa-Illinois serves, unemployment and underemployment continue to cause severe economic hardships for families and individuals. During the 1988-89 heating season, 10,136 of Iowa-Illinois' customers received an average of $181.00 in federal LIHEAP assistance. Customers in Iowa-Illinois' service territory rely on gas or electric heat at least six months out of each year. An average Iowa-Illinois LIHEAP customer, receiving only $181.00 this past heating season, has a difficult time fulfilling his or her financial responsibilities when he or she receives so little federal assistance for heat.

In response to this need, Iowa-Illinois continues to promote its own voluntary program funded by customers and shareholders to assist needy families with their energy costs. Since this program was implemented in 1982, over $900,000 has been contributed to provide assistance to approximately 10,500 households. Still, private efforts such as Iowa-Illinois' are not enough to meet the need.

Some argue that the states will increase their funding of low-income heating payment assistance programs if the federal government decreases its commitment. This is not the case in Iowa or Illinois. Iowa has no state-wide payment assistance program in place to supplement LIHEAP assistance. Furthermore, Iowa has used much of the oil overcharge funds it has received to support programs unrelated to heating assistance. For the past four years, Illinois has had a percent of income plan in place to assist low-income heating customers. This plan was funded through a $40 million appropriation of oil overcharge funds. However, those $40 million have been depleted and, for lack of a long-term funding source, the Illinois plan's future is uncertain.

Again, Iowa-Illinois does not support a decrease in federal appropriations to the LIHEAP Program. Furthermore, Iowa-Illinois feels that an increase in 1990 funding to $1.44 billion is warranted to keep pace with inflation.

Iowa-Illinois Gas and Electric Company thanks the Committee for its consideration of this written testimony.

STATEMENT OF ROBERT J. PATRYLO, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PHILADELPHIA GAS WORKS

Thank you for the opportunity to submit this written testimony in support of federal funding for the Low Income Home Energy Assistance Program (LIHEAP). On Wednesday, May 3, 1989, Mr. Don Heim, Chairman and Chief Executive Officer of Washington Gas Light and Mr. Anthony E. Ard, Vice President of Indiana Gas Company, Inc. presented testimony on behalf of the American Gas Association before the House and Senate subcommittees requesting that there be no further cut or reductions in the LIHEAP Program.

My name is Robert J. Patrylo, President and Chief Executive Officer of the Philadelphia Gas Works. PGW, along with other members of the American Gas Association is deeply committed to meeting the energy needs of all our customers, especially those with low or fixed income.

As you are aware, the administration is proposing an appropriation of $1.1 billion for Fiscal Year 1990. This represents a 21 percent cut over Fiscal Year 1989's funding level and an approximate 50% cut in the program since 1985 when the allocation was $2.1 billion.

I believe that everyone realizes that this is a very difficult budget year, and that your job in deciding how the money will be allocated is not an easy one. However, I feel strongly that the LIHEAP Program has already taken its share of cuts. LIHEAP cannot survive with any degree of effectiveness if these cuts continue. This is why PGW along with other AGA member companies support a funding level of $1.4 billion, which is equivalent to the Fiscal Year 1989 appropriation plus inflation.

I do not want to imply that the burdens of the low-income customers needs rests solely on the shoulders of the federal government.

Since 1983, PGW has been actively involved in a partnership with the Utility Emergency Service Fund. UESF is a private non-profit organization dedicated to resolving utility crises by funding low-income Philadelphia households. It was obvious to PGW very early on that local needs outpaced the federal LIHEAP commitment. PGW, along with other community and corporate leaders, the city government, and the gas, water and electric utilities, formed UESF to meet a common goal: to help the poor keep essential utility services for their homes. Since that time, through the collective efforts of everyone, over 28,000 Philadelphia households -- some 80,000 people have been helped.

In 1988, PGW matched dollar for dollar every dollar donated to UESF which resulted in $2.7 million to help 7,094 gas, electric and water users to keep their utilities on. In addition, funds are also contributed for UESF's operating expenses, so 100% of all donations are used to provide assistance to the poor.

Programs like UESF cannot pull the whole load for LIHEAP, no matter how successful. It has been our experience that the LIHEAP component is a crucial element in the provision of energy needs for low-income consumers.

For example, in 1987, LIHEAP provided approximately $9,000,000 for our service area, reaching over 40,000 customer accounts. In that same year UESF raised some $2.7 million or 30% of the LIHEAP commitment. However in 1985, when the LIHEAP funding was at its peak, over 45,000 PGW customers shared in over $12,000,000 of assistance from the LIHEAP Program. As stated earlier, UESF raised some $2.7 million or 30% percent of the LIHEAP commitment.

Although fuel prices may have stabilized, low income families still spend 13-15% of their income on energy contrasted with four percent (4%) paid by the average American family.

With regard to the oil overcharge settlement funds, in the state of Pennsylvania our funds are almost totally depleted. Additionally, the National Consumer Law Center has reported to the Department of Energy that 95 percent of these funds that were available nationwide have been allocated by the states. Thus, the oil overcharge funds cannot be relied upon to fill the gap left by reductions in the LIHEAP funds.

Therefore, it is with a sense of urgency that I respectfully request that you recognize LIHEAP as a vital program for the disadvantaged of this nation and approve a funding level of $1.4 billion for Fiscal Year 1990.

STATEMENT OF MARGARET WILLIAMS, PRESIDENT, THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

The National Association of Area Agencies on Aging, on behalf of our member agencies, is pleased to present this statement for the record of the Subcommittee's hearing on the FY 1990 Health and Human Services Appropriations.

The National Association of Area Agencies on Aging (NAAAA) is the national organization representing the network of over 660 Area Agencies on Aging. Area Agencies on Aging were established, as a result of the 1973 amendments to the Older Americans Act, to address the needs of older Americans aged 60 and over within each local community. The Area Agency on Aging is the vital link between the local community and many of the Federal and State programs available to older persons. Area Agencies on Aging are charged with assuring the availability of a comprehensive array of services for the elderly, and they are responsible for developing and coordinating locally-based social and nutritional services which help older persons remain independent in their own homes and communities. The primary mission of Area Agencies on Aging is to: (a) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate support services; (b) remove individual and social barriers to economic and personal independence for older persons; and (c) provide a continuum of community-based and in-home care for the vulnerable elderly, thereby avoiding premature or inappropriate institutionalization.

Our testimony will focus on several areas of concern: (a) the funding freeze proposed in the Reagan/Bush budgets and its impact of Older Americans Act Title III programs, (b) funding for Title VI Grants for Native Americans, and (c) an administrative budget for the Administration on Aging.

Inadequacies of the Administration's Proposed FY 1990 Budget

The Reagan administration's budget proposal for FY 1990 called for a freeze on Older Americans Act Title III support services and nutrition programs at the FY 1989 level of $716.7 million. Unfortunately, the budget modifications proposed by President Bush do not contain any additional funding for Older Americans Act programs. While the Administration proposed increased support for some social programs, their concept of "flexible freeze" means that other programs will have to compete with one another for funding. Rather than seeking to provide support for programs that help a broad spectrum of our citizens, the Administration's budget approach, instead, results in special needs populations having to compete against one another for funding. Thus, children must vie with the handicapped, who are in competition with the ill, who, in turn, must seek funding from programs for the elderly. This approach to funding services programs does not make for a "kinder and gentler" nation.

One of the populations who will be hurt by this approach are the elderly of this nation. Due to the effects of the rate of inflation and the increased growth in the number of individuals age 60 and above, and thus eligible for Older Americans Act programs, a FY 1990 funding freeze at the FY 1989 level is, in effect, a reduction in funding. Not only will Area Agencies on Aging have increased difficulty in providing services to current clients, but they will be under increased financial strain to provide services to those newly eligible. This does not take into account those senior citizens who are not now being fully or adequately served by Older Americans Act programs, such as ethnic and cultural minority elderly and the elderly in some rural areas. For these elderly to receive services, special outreach efforts need to be made.

NAAAA recently conducted a mail survey of a sample of the national network of Area Agencies on Aging to determine: (a) the number of older persons being served, (b) whether the level of service delivery is increasing or decreasing, and (c) whether the funding for services is increasing or decreasing. Selected Area Agencies on Aging were asked to provide information on nine selected services. These services included congregate meals, home-delivered meals, long-term care ombudsman programs, personal care services, legal services, transportation, elder abuse and neglect programs, care/case management, and health screening programs. For fiscal years 1987, 1988, and Estimated 1989, information was requested on each of the nine services, including: (a) the number of persons served, (b) units of service, (c) total expenditure for the service, and (d) the amount of federal contribution received for the service. Responses were received from 45 Area Agencies on Aging, representing 27 states, the 10 Federal regions, large and small Area Agencies on Aging, and from urban, suburban, and rural areas.

To summarize the results, in spite of increased inflation and a lack of substantial increases in Federal funding for Older Americans Act programs, Area Agencies on Aging are serving more older persons. State and local funding, as well as administrative efficiencies and some client contributions, have helped expand the programs to reach more older adults. Each of the nine services areas examined were utilized by an increased number of persons between 1987 and Estimated 1989, and there was generally an increase in the number of units of service per individual. While the level of increase in utilization has generally been modest, funding levels have not allowed the outreach efforts necessary to reach the number of additional older persons who need and could benefit from Older Americans Act programs. The Title III services which continue to be in high demand are meal programs, both congregate and in-home, transportation, and legal services. There is an increased demand for such services as case/care management, abuse/protection/neglect services, and for health screening. It is likely that demand for these services will continue to increase. Title III is not funded at a level high enough to meet the demand for services. Through numerous Congressional hearings, it has been documented that the elderly from racial, cultural, and linguistic minority populations are not being adequately served by Title III programs. **To reach these harder to access elderly and to continue to provide services to the growing number of non-minority elderly requires funding above the FY 1990 Administration proposed budget.**

The National Association of Area Agencies on Aging recommends that Older Americans Act programs be funded at a level which will allow needed services to be provided to all eligible older persons. Due to the increasing rate of inflation and the growth in the number of older persons seeking services over the years, we recommend an appropriations increase of at least 14 percent.

Funding for Title VI Programs

The Older Americans Act Title VI, Grants for Native Americans, program continues to be seriously under-funded. Under the Title VI program for older Indians, there were 136 Title VI grantees that provided support and nutrition services. The FY 1989 appropriation for Title VI is $7.4 million (of an authorization of $16.3 million). In 1988, the Administration on Aging added 45 new tribes to the Title VI program, but without an accompanying increase in funding to cover all of the new grantees. Thus, the FY 1989 budget must now be divided between 181 Indian tribes. The reduction in funding to existing Title VI grantees has resulted in cut backs of 16% to over 50%, and has severely reduced and jeopardized the existence of older Indian programs. This reduction in funding to existing grantees is having a devastating impact on elderly programs. For example:

> The Chickasaw Nation, in Oklahoma, had their budget reduced from $80,110 in FY 1988 to $49,621 in FY 1989, a 38% reduction in funding. The budget cut will result in the Chickasaw Nation Senior Citizens Program reducing its meal program from serving 225 seniors on a daily basis to providing meals to only 100 seniors three days per week; home-delivered meals will be reduced from 90 meals per day to 10 meals per day; aging services staff will be reduced by seven members, and reductions will be made in other support programs.
>
> The Eastern Band of Cherokee, in North Carolina, had their budget reduced from $76,700 in FY 1988 to $43,333 in FY 1989, a 44% reduction in funding. The budget cut will result in a reduction in home-delivered meals from 27 per day to 5 per day; reduction in transportation services; no services will be provided to the 150 elderly living in more remote areas; and staff hours will be reduced.

We are pleased to note that there is support in Congress for a supplemental appropriation to help ease the funding crisis from the addition of the new Title VI grantees. We understand that the amount currently being discussed for the supplemental appropriation is $3.3 million, with approximately $2.3 million being drawn from Title IV FY 1989 funds and $1 million from Title III FY 1989 funds. **While NAAAA wholeheartedly supports a supplemental appropriation for the Title VI programs, we are greatly concerned that the funding is being taken from other Older Americans Act programs.** Since 1980, we have witnessed the erosion of funding for Title IV Training, Research, and Discretionary Grants Projects and Programs. This is unfortunate as Title IV has helped improve the training of those who work with older adults and has provided funding for research and demonstration grants to develop programs and methods to better serve older persons. Likewise, we are concerned about funds being shifted from Title III Grants and Community Services Programs on Aging. **We strongly urge that the funding from Titles III and IV be restored in the FY 1990 appropriation.** It would be most unfortunate if the shifting of funds for the supplemental appropriation signaled a reduction in these

other important programs. We also recommend that for FY 1990 that additional funds be appropriated for Title VI programs, and that this increase in funding be commensurate to adequately fund both new and existing Title VI grantees.

Separate Administrative Budget for the Administration on Aging

NAAAA is concerned that the current method of administrative budgeting for the Administration on Aging (AoA) does not reflect the Congressionally mandated relationship between the Commissioner on Aging and AoA with the Secretary of Health and Human Services. Section 201 of the Older Americans Act amendments of 1987 (P.L. 100-175) stipulated that:

> "There shall be a direct reporting relationship between the Commissioner and the Secretary. In the performance of the functions of the Commissioner, the Commissioner shall be directly responsible to the Secretary. The Secretary shall not approve or require any delegation of the functions of the Commissioner to any other officer not directly responsible to the Commissioner."

The current method of budgeting for AoA administrative functions is through a single Congressional appropriations for the Office of Human Development Services. This does not reflect the special relationship between the Commissioner and the Secretary specified by Congress. Our concern is that while AoA is responsible for administering and monitoring a broad array of Older Americans Act programs, it does not have operational control of its administrative budget to allow the Commissioner to provide leadership and oversight to the national aging network. For example, AoA does not have budget development or administrative control over the salaries and benefits of its employees, travel, supplies and materials, or equipment. These are items within the purview of most private, as well as public, departmental supervisors, yet management control is denied the Commissioner on Aging. We believe that the Commissioner on Aging, who has the responsibility for Older Americans Act programs, should have the authority and control over the administrative budget of AoA. **We recommend that Congress fully review the administrative needs of the Administration on Aging and allocate funds through the use of a separate line item appropriations, sufficient to meet their ongoing operational and programmatic needs.**

The National Association of Area Agencies on Aging thanks the Subcommittee for this opportunity to express our views on the FY 1990 appropriations for Older Americans Act programs and activities. We support this Subcommittee's efforts to improve community-based support programs for this nation's elderly.

STATEMENT OF JANET PARRISH, CHAIRPERSON, NATIONAL FUEL FUNDS NETWORK AND EXECUTIVE DIRECTOR, UTILITY EMERGENCY SERVICES FUND

THANK YOU FOR THE OPPORTUNITY TO SUBMIT THIS WRITTEN TESTIMONY, SUPPORTING RESTORATION OF FUNDING FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) IN FFY 1990 TO THE MINIMALLY ADEQUATE LEVEL OF $2 BILLION.

THE NATIONAL FUEL FUNDS NETWORK (NFFN) IS A MEMBERSHIP ORGANIZATION COMPRISED OF 120 DUES-PAYING REPRESENTATIVES OF PRIVATE FUEL FUNDS, COMMUNITY ACTION AND OTHER SOCIAL SERVICE ORGANIZATIONS, UTILITIES, REGULATORS AND OTHERS, FROM THREE-FOURTHS OF THE STATES.

THUS, WE REPRESENT A NATIONAL, GRASS-ROOTS LEVEL PERSPECTIVE ON THE DIMENSIONS OF THE ENERGY/POVERTY PROBLEM. OUR MEMBERS SHARE A COMMITMENT TO INCREASING THE FINANCIAL AND HUMAN RESOURCES AVAILABLE TO ADDRESS THE ENERGY NEEDS OF LOW INCOME HOUSEHOLDS. THE NFFN HAS BEEN IN EXISTENCE FOR FIVE YEARS, SERVING AS A CLEARINGHOUSE FOR INFORMATION EXCHANGE AND TECHNICAL ASSISTANCE FOR THE ONE HUNDRED-PLUS PRIVATE FUEL FUNDS THAT HAVE DEVELOPED IN RECENT YEARS, IN AN EFFORT TO SUPPLEMENT INADEQUATE LIHEAP FUNDING AT THE LOCAL LEVEL.

AS PRIVATE SECTOR, COMMUNITY-BASED EFFORTS TO PROVIDE LAST RESORT EMERGENCY ENERGY ASSISTANCE TO SOME OF OUR COUNTRY'S NEEDIEST AND MOST VULNERABLE CITIZENS, WE HAVE SEEN FIRST-HAND THE SERIOUS, NEGATIVE CONSEQUENCES OF ONGOING REDUCTIONS IN FEDERAL FUNDING FOR LIHEAP. ACCORDING TO A RECENT SURVEY WE CONDUCTED IN COOPERATION WITH THE EDISON ELECTRIC INSTITUTE AND THE AMERICAN GAS ASSOCIATION, OUR PRIVATE SECTOR FUNDRAISING EFFORTS CONTRIBUTE AT LEAST $31 MILLION ANNUALLY AS A CRITICAL SUPPLEMENT TO LIHEAP FUNDING ON BEHALF OF NEARLY 200,000 HOUSEHOLDS; YET THIS IS FAR FROM EVEN APPROACHING CLOSING THE GAP LEFT BY RECENT YEARS' DRASTIC FEDERAL FUNDING CUTS. THIS DOES, HOWEVER, INDICATE STABILITY IN THE PRIVATE SECTOR'S CONTRIBUTION DURING YEARS WHEN--BY CONTRAST--THE FEDERAL GOVERNMENT HAS SLASHED FUNDING BY 33%

ALTHOUGH WE HAVE FOUND THAT THERE ARE MANY GENEROUS INDIVIDUALS WHO CONTRIBUTE A FEW DOLLARS, OR MORE, EVERY YEAR TO HELP THEIR LESS FORTUNATE NEIGHBORS, WE ALSO FIND THAT MANY POTENTIAL CONTRIBUTORS--INDIVIDUALS AND CORPORATIONS ALIKE--WANT TO KNOW WHY GOVERNMENT IS NOT FULFILLING ITS RESPONSIBILITY TO SUPPORT AN ADEQUATELY-FUNDED LIHEAP. THIS SENSE THAT GOVERNMENT IS NOT DOING ENOUGH TO ASSIST THE POOR WAS REFLECTED IN RESPONSES TO A RECENT NATIONWIDE GALLUP SURVEY, PUBLISHED FOR INDEPENDENT SECTOR AS GIVING AND VOLUNTEERING IN THE UNITED STATES. WE CAN RESPOND TO THIS VERY REAL AND LEGITIMATE CONCERN ONLY BY BRINGING IT DIRECTLY TO YOUR ATTENTION.

NOTWITHSTANDING THE MISLEADING USE OF STATISTICS BY THE ADMINISTRATION (WHICH REFERRED TO A WARMER WINTER TO "PROVE" THAT

ENERGY COSTS ARE NO LONGER AS BURDENSOME TO LOW INCOME HOUSEHOLDS), WE REMAIN PAINFULLY AWARE THAT THE PEOPLE WE SERVE STILL HAVE TO DEVOTE 15% OF THEIR INCOMES TO COVER THEIR ENERGY BILLS--FOUR TIMES WHAT THE TYPICAL MIDDLE INCOME FAMILY MUST DO. FOR THE POOREST OF THE POOR, THE BURDEN IS EVEN HIGHER! MANY OF OUR MEMBER FUEL FUNDS REPORT IT WOULD TAKE ONE-THIRD OF THEIR CLIENTS' INCOMES TO COVER ESSENTIAL HOME ENERGY COSTS--CLEARLY, AN IMPOSSIBLE BURDEN.

WHAT, THEN, ARE THE RESULTS LOCALLY? YOU ARE ALREADY AWARE OF THE MANY STATES IN WHICH LIHEAP PROGRAMS HAVE HAD TO OPERATE A SHORTENED PROGRAM YEAR, SERVING FEWER HOUSEHOLDS THAN PREVIOUSLY, OR HAVE BEEN FORCED TO REDUCE FURTHER ALREADY INADEQUATE BENEFIT LEVELS, OR HAVE EXCLUDED NEEDY HOUSEHOLDS FROM HELP WITH THEIR HEATING BILLS THROUGH REDUCTION OF INCOME ELIGIBILITY MAXIMUMS. THIS IS TRUE EVEN WHERE OIL OVERCHARGE FUNDS HAVE BEEN USED TO SUPPLEMENT FEDERAL LIHEAP FUNDS. OUR MEMBERS REPORT THAT SUCH PROGRAM CUTBACKS RESULT IN EVEN GREATER DEMAND FOR OUR VERY LIMITED AND SEVERELY-STRAINED PRIVATE SECTOR RESOURCES.

AND, WE HAVE BEGUN TO DOCUMENT EVEN MORE SEVERE CONSEQUENCES OF FEDERAL FUNDING CUTS. DUE TO THEIR INABILITY TO PAY THEIR ENERGY COSTS BY THEMSELVES OR WITH THE MINIMAL ASSISTANCE AFFORDED BY LIHEAP, MANY HUNDREDS OF THOUSANDS OF LOW INCOME HOUSEHOLDS SUFFER TERMINATION OF THEIR HEAT AND UTILITY SERVICES, OR LOSS OF OTHER HEATING FUEL SUPPLIES. YOU ARE WELL AWARE OF THE LIFE AND HEALTH-THREATENING HARDSHIPS THAT CAN RESULT. BUT, WERE YOU ALSO AWARE THAT SUCH LOSS OF SERVICE CAN RESULT IN FAR TOO MANY CASES IN ABANDONMENT OF PROPERTIES, WITH ITS CONCOMMITANT DETERIORATION OF NEIGHBORHOODS AND CITIES AS A WHOLE.

STATISTICS COMPILED IN PHILADELPHIA OVER THE PAST SEVERAL YEARS DEMONSTRATE A CASE IN POINT. ANNUAL SURVEYS ARE PERFORMED IN DECEMBER OF EACH YEAR OF THOSE ACCOUNTS TO WHICH GAS AND/OR ELECTRIC SERVICE HAS BEEN TERMINATED DURING THE PRIOR YEAR BUT NOT YET RESTORED. RESULTS FROM THE 1985 TO 1988 SURVEYS BY PHILADELPHIA GAS WORKS AND PHILADELPHIA ELECTRIC COMPANY CONSISTENTLY REVEAL THAT THOUSANDS OF PROPERTIES ARE FOUND TO BE VACANT EACH YEAR!

(SIMILAR RESULTS WERE FOUND BY THE PHILADELPHIA WATER DEPARTMENT IN ITS 1987 SURVEY AS WELL.) HUNDREDS OF ADDITIONAL FAMILIES WERE FOUND TO BE LIVING IN THEIR HOMES TOTALLY WITHOUT ANY SOURCE OF HEAT. AND, OF COURSE, THOUSANDS MORE WERE RELYING ON POTENTIALLY HAZARDOUS SPACE HEATERS OR HEAT FROM RANGE-TOP BURNERS.

THE NFFN BELIEVES THAT THE FURTHER EXACERBATION OF THIS DIRE SITUATION THAT WILL UNDOUBTEDLY RESULT FROM FURTHER SHRINKAGE OF FEDERAL ENERGY ASSISTANCE RESOURCES IS, SIMPLY, UNACCEPTABLE. WE IN THE PRIVATE SECTOR ARE COMMITTED TO SUSTAINING OUR PUBLIC/PRIVATE PARTNERSHIP EFFORTS LOCALLY, TO PROVIDE NECESSARY SUPPLEMENTS TO GOVERNMENTAL FUNDING. MANY OF US HAVE HELPED ENSURE THAT STATES USED OIL OVERCHARGE FUNDS (WHICH OF COURSE ARE NOW VIRTUALLY DEPLETED), AND EVEN STATE REVENUES, SIMILARLY TO SUPPLEMENT LIHEAP DOLLARS. WE AGREE THAT AT THE LOCAL AND STATE LEVELS, WE MUST BE PARTNERS IN THE EFFORT TO PROVIDE THE NECESSARY RESOURCES TO ADDRESS EFFECTIVELY THE PERSISTENT AND COMPLEX ENERGY/POVERTY CRISIS WE FACE IN THIS COUNTRY. BUT, IF WE ARE TO PRESERVE ANY KIND OF MEANINGFUL ENERGY SAFETY NET FOR OUR MOST VULNERABLE CITIZENS, WITHDRAWAL OF THE FEDERAL GOVERNMENT AS A PARTNER IN THIS EFFORT MUST CEASE, AND INDEED, MUST BEGIN TO REVERSE ITSELF. PARTICULARLY AT A TIME WHEN THE FEDERAL TREASURY IS THE REPOSITORY OF $1 BILLION IN STRIPPER WELL FUNDS, THE FURTHER 20% REDUCTION IN FFY 1990 FUNDING PROPOSED BY THE ADMINISTRATION IS UNTHINKABLE. IN ACCORDANCE WITH RESOLUTIONS PREVIOUSLY ADOPTED UNANIMOUSLY BY OUR MEMBERSHIP, AS WELL AS ACTION TAKEN BY OUR BOARD OF DIRECTORS, WE RESPECTFULLY BUT URGENTLY COMMEND TO YOU RESTORATION OF LIHEAP FUNDING IN FFY 1990 TO THE RANGE OF $2 BILLION, AS A MATTER OF HUMANE, FAIR AND SOUND PUBLIC POLICY.

THANK YOU FOR YOUR CAREFUL CONSIDERATION OF THIS TESTIMONY.

STATEMENT OF JAMES F. DIETERLE, CUSTOMER SERVICES PLANNING, PUBLIC SERVICE & ELECTRIC CO.

My name is James F. Dieterle and I am Manager - Customer Services Planning for Public Service Electric and Gas Company (PSE&G). PSE&G strongly recommends an increase in funding for the next winter's Low Income Home Energy Assistance Program (LIHEAP). Without adequate funding, there will be thousands of low-income PSE&G customers who will be unable to afford their heating and cooling needs. Last year over 47,000 low-income PSE&G customers used LIHEAP assistance to help pay their heating and cooling costs. Without these funds, many of these consumers would have eventually lost their electric and/or gas service or suffered in other areas. This March, there are well over 100,000 shut-off notices mailed to PSE&G customers who were behind in paying their bills. More then 500,000 PSE&G customers owed more then one month's service. Many of these customers are senior citizens or single parents who do not have the resources to pay for the gas or electricity required for their heating service. Spring, 1989, saw a premature exhaustion of LIHEAP funds due to inadequate funding. Thousands of our customers will now have great difficulty in paying off their winter bills and in maintaining their electric and/or gas service.

PSE&G respectfully submits that the upcoming LIHEAP level should be increased to avoid severe hardship to its low-income citizens. It is essential for their ability to afford the gas and electricity they require. The bottom line is that someone who qualifies for LIHEAP in New Jersey absolutely requires assistance in order to meet their heating and/or medically required cooling costs. Without adequate funding of LIHEAP, these customers can literally be without any other alternatives.

STATEMENT OF GERARD C. MILLER, VICE PRESIDENT, NATIONAL FUEL GAS DISTRIBUTION CORP.

I am Gerard C. Miller, Vice President of National Fuel Distribution Corporation. National Fuel is a natural gas utility serving nearly 680,000 customers in Western New York and Northwestern Pennsylvania.

We realize the enormous task you and your fellow Congressmen face in coping with the federal budget. We wish to commend you for taking the time to give us this opportunity to present an appeal in support of a most important portion of that budget.

The proposed cuts in the funding of the Low Income Home Energy Assistance Program (LIHEAP) give us great concern. As a utility, National Fuel has made a commitment to its customers to meet their energy needs. This pledge applies to our low-income customers as well as those with the ability to pay their energy bills.

Cuts in the LIHEAP allocation have reduced funding for this program from $2.10 billion in 1985 to $1.383 billion in 1989--a 34 percent decrease in monies. The administration has proposed an additional 20 percent reduction. These cuts will seriously damage the effectiveness of the program at a time when the energy cost burden for low-income customers is about to become more severe.

We recognize that the private sector and the government share an obligation to address the problems of poverty. National Fuel has instituted a number of programs to assist our low-income customers. The CARES program in our Pennsylvania division is administered by trained social workers who provide assistance to our payment-troubled customers. These employees help the troubled customer to obtain financial aid, not only for gas bills but for other expenses as well. We have weatherization programs available in both New York State and Pennsylvania. In New York State, we have employed an Energy Packager to address all of the energy needs of low-income senior citizens.

Our fuel fund, the Neighbor-4-Neighbor Fund is approaching $1 million in energy assistance to qualifying senior citizens. Although this fund is extremely effective, and the $1 million figure is an impressive one, it can only supplement the LIHEAP program and could never replace it.

Many of our low-income customers have found LIHEAP assistance to be vital in order to meet the costs of their life necessities. The funding cuts have already caused a reduction in the number of grants in our service area. In 1984, almost $30 million in LIHEAP monies were received by our customers systemwide, reaching well over 100,000 customers. In 1988, only about $23 million in LIHEAP benefits were distributed to 88,000 customers. The working poor and elderly, who are spending about 15 percent of their total income on energy, find this further reduction in aid to be most oppressive and are having to make great sacrifices in order to make ends meet.

I am sure you are aware of the fact that, with the severe weather in the northern half of the nation, a utility's ability to terminate service during the winter is restricted, even for customers with an ability to pay. You may also know that energy costs are once again beginning to climb. This rise means that the plight of payment-troubled customers will worsen and many customers marginally able to pay their bills today will in all likelihood become payment-troubled customers. These factors will combine to exacerbate the pricing problem by increasing charge-offs and creating still higher rates for our remaining customers.

In view of these concerns, I respectfully urge you to abstain from any further reductions in LIHEAP allocations and ask you to consider increasing the funding to a more meaningful level.

STATEMENT OF BILL STEINBERG, DIRECTOR, REFUGEE EMPLOYMENT, LUTHERAN SOCIAL SERVICES OF SOUTHERN CALIFORNIA

My name is Bill Steinberg. I am here representing Lutheran Social Services of Southern California. Lutheran Social Services, like the other religiously based organizations, has been involved in assisting immigrants and refugees coming to our shores since before the founding of this nation. For over two centuries, Lutherans and other religious bodies have helped their own. This tradition continued until the nineteen-forties when the major dislocations that occurred during and after the Second World War created problems of a magnitude that the social service arms of American churches and synagogues could no longer handle. The various organizations looked to their government for assistance.

After the war, the failed revolutions against communism in Eastern Europe forced additional thousands to seek protection on our shores. This was followed by the fall of the Saigon government in 1975. With the arrival of the huge number of people fleeing the communists in Indochina, it became painfully clear that the tradition of privately financed and privately operated resettlement could no longer be the sole model.

The private resettlement agencies turned again to their government for assistance - and a wise partnership was created. The traditional resettlement agencies would continue to handle the job of resettlement, under guidelines established by Congress. The states would administer the programs within their boundaries - and the Federal Government would set the limits of resettlement, establish admission ceilings, create the guidelines, and fund the cost of resettling the refugees for their first 36 months in the U.S.

This partnership held fairly strongly through the first years after Congress passed the landmark Refugee Act of 1980. In recent years however, there has been a steady erosion of the Federal government's commitment to this program. The period of federal reimbursement to states and counties has been continuously decreased. As others here have testified, the Administration is now proposing cuts in its responsibility that will make a dignified and honorable resettlement of these proud but needy people virtually impossible.

Under the proposed cuts, there will not be enough resources for even minimal English instruction. Vital health screening programs will be decimated, programs geared to job training and job placement will be cut so much that only a fraction of the needy will be assisted. In short, some fortunate refugees may be admitted, but then all assistance and humanitarian concern will abruptly cease.

We live in an era of major budget deficits. We cannot provide everything that the less fortunate need. Still, it is very hard to believe that we cannot provide the minimum that we demand for our own childrden - English instruction, health care and assistance in finding their first jobs.

I can assure you, Ladies and Gentlemen, that the private sector remains fully committed to helping the needy in our society. However, we are concerned and saddened when our leaders seem willing to walk away from a responsibility that goes to the very spiritual heart and foundation of this nation. Please don't let this happen.

STATEMENT OF WALTER BARNES, CHIEF, REFUGEE AND IMMIGRATION PROGRAMS BRANCH, STATE OF CALIFORNIA

Thank you for the opportunity to comment on the proposed Federal Fiscal Year (FFY) 1990 Budget for the Refugee Resettlement Program.

Regardless of their country of origin, most refugees have a number of barriers which must be overcome if they are to become successfully resettled and self-sufficient. Most have little or no English language capability or competitive job skills or education. In addition, many have been traumatized by their refugee experience and are confused by their new culture. (A report from the California State Department of Mental Health indicates that 50 percent of all refugees need some level of mental health services.) Finally, they come with no personal resources and are often resettled in a community made up of like individuals.

The consequence is that many enter the welfare system as the only alternative available to maintain themselves and are at risk to stay there for a long time.

The framers of the original Refugee Act recognized that these problems would occur and so created the following agreement in the Act between the Federal and State/Local Governments:

- The Federal Government would decide who was a refugee, whether they should be admitted and where they would be located.
- The State/Local Governments would take responsibility for the long-term successful integration of refugees into society through the provision of cash, medical, employment and other services.
- In return, the Federal Government agreed to provide the State/Local Governments with funding to address the barriers previously mentioned.

This basic agreement is a sound one in that it allows the Federal Government to set and conduct foreign policy and provides the State/Local Governments with resources to cover the consequences of that policy.

However, the federal commitment for funding has been eroded over the last several years by budgetary decisions which have transferred the costs of resettlement to the State/Local Governments and reduced services needed to assist refugees to become self-sufficient.

The effect of these decisions is illustrated by the attached graph. This shows that federal funding has been reduced drastically since FFY 1985, the last year when funding consistent with the Refugee Act was provided, even as the level of refugee admissions has been increasing. Specific information on the reductions is given in the enclosure entitled SUMMARY OF FUNDING REDUCTIONS AND COST TRANSFERS TO THE STATES.

The exact amount will depend on the final numbers the State Department wishes to admit during FFY 1990 and whether the level of refugee admissions is increased this year, as has been proposed.

We realize that this is a time of fiscal constraints. However, please remember that States have no control over the admission of refugees. In addition, the increases we are requesting are only consistent with the original agreements in the Refugee Act. Finally, the additional funding is vital if State/Local Governments are expected to continue to meet their responsibilities under the Refugee Act.

If the funding is to be allowed to deteriorate as it has in the past, then these responsibilities should be reexamined. However, in the absence of any changes, the agreement embodied in the Refugee Act should be reflected in the budget.

The proposed FFY 1990 Budget would also reduce funding for English language, vocational training, employment and other service programs. This would be done by reducing Social Services funding by nearly 55 percent and eliminating the Targeted Assistance Program entirely. This is a net cut for these programs of 75 percent when compared to FFY 1985. This would severely cripple States' efforts to assist refugees to become self-sufficient and would prolong welfare dependency.

Finally, a cut of nearly 50 percent is proposed for preventive health. This is a 70 percent cut since FFY 1985. If this takes place, States will be left with the choice of funding this cut with their own General Funds or risking the spread of untreated communicable diseases to the public.

During the same period of time these cuts were made, the number of refugees being admitted was increasing and the proposed admission levels for FFY 1990 will be nearly 25 percent higher than FFY 1985.

Thus, it can be estimated that the proposed FFY 1990 budget for the Refugee Resettlement Program represents only about one-third of the funding intended under the Refugee Act. This means that the funding levels for Cash, Medical and Administration, Social Services, Targeted Assistance and Preventive Health should be increased from the proposed $235 million to between $600 and $700 million.

Most of the federal refugee funding is provided under Cash, Medical and Administration. This is intended to hold the State/Local Governments harmless for the costs of cash and medical programs provided to refugees during the first 36 months they are in the country. Under the Refugee Act, States are only supposed to be responsible for costs of these programs after 36 months.

However, the federal budget in the current year only provides sufficient funding for 24 months and the Administration's proposed Budget for Federal Fiscal Year (FFY) 1990 would reduce this to 15 months. This is nearly a 60 percent reduction since FFY 1985.

For cash assistance programs alone in California, State/Local general funding of over $290 million will be required for payments to refugees in the country for more than 24 months. This is approximately $27 million more than would be required if the full 36 months was provided. If the reduction to 15 months is allowed an additional $27 million in general funding will be required.

Thus the State/Local Governments are being required to continue to pay for the large costs of cash and medical assistance to refugees over 36 months at the same time that they are being asked to pick up amounts that the federal government is supposed to cover under the Refugee Act. This seems unfair, especially when the costs result from foreign policy decisions over which the State/Local governments have no control.

STATEMENT OF NGUYEN ANH, EXECUTIVE DIRECTOR, ECONOMIC AND EMPLOYMENT DEVELOPMENT CENTER

Mr. Chairman, Members of the Subcommittee, my name is Nguyen 'Andy' Anh, Executive Director of the Economic and Employment Development Center for the refugees in Los Angeles County, California, Chairman of the State Advisory Council on Refugee Assistance and Service, State of California and a representative of the emerging network of refugee self-help and service organizations in the U.S.

State and local governments, refugees and service organizations nationwide are very concerned about the gap between "Increasing Refugee Admissions to the United States" and "Decreasing Support/Training Service Funding" in the Federal Budget for Fiscal Year 1990, with disproportionate consequences on existing refugee impacted areas.

INCREASING REFUGEE ADMISSIONS

The Federal refugee admission planning projected the arrival of some 116,000 refugees in fiscal year 1990, the number for current fiscal year is only 84,000. This increase is due substantially to changes in the Soviet Union policies which will allow more Soviet Armenians and Jews to leave the country. The new quota for refugee for fiscal year 1990 is the highest level of any year since 1984.

DECREASING SUPPORT/TRAINING SERVICES

Refugee Employment Service funding is being reduced, however, from $65 million in 1989 to $30 million in 1990. Targeted Assistance is being reduced from $34 million to zero.

DISPROPORTIONATE IMPACT

In the State of California, the Los Angeles County situation may illustrate the circumstances of other impacted area.

90% of the Soviet Armenians, according to the Department of State, have resettled and will resettle in the Los Angeles area. A disproportionate number of Amerasian children and their families will also resettle or relocate to Los Angeles, this is in addition to the regular flow of Southeast Asian refugees.

The Office of Refugee Resettlement (ORR) proposed " across the board " cuts in the refugee assistance programs nationwide translate into a negative impact, in quantum terms, upon the capacity of the local governments and the community based organizations to help the new arrivals.

CONCLUSION

Mr. Chairman, Members of the Sub-committee, with the refugee funding levels approved by Congress in the past years, 1984-1989, for refugee Employment Services and Targeted Assistance, the Los Angeles County, for instance, has been able to place approximately 20,000 refugees in jobs, thereby saving millions of dollars in welfare costs.

Most of the refugees who have been helped by these programs are now self-sufficient, productive members of our society and the cost of their assistance has been repaid several times over.

We respectfully request Congress to Increase Refugee Employment Services and Targeted Assistance program for fiscal year 1990 to the 1986 fiscal year level to account for the increase in the national refugee admission quota.

Mr. Chairman, Members of the Sub-committee, thank you very much.

LETTER FROM MICHAEL BALY III, EXECUTIVE VICE PRESIDENT, AMERICAN GAS ASSOCIATION

Honorable Tom Harkin
Chairman
Subcommittee on Labor, HHS, Education and
Related Agencies
Appropriations Committee
United States Senate
Room SD-131
Washington, DC 20510

May 15, 1989

Dear Chairman Harkin:

In testimony before your Subcommittee on May 3, the witness for the American Gas Association, Anthony E. Ard of Indiana Gas Company, promised to submit additional information for the record. Because of time limitations on the speakers' presentations, we are submitting these data for the hearing record to supplement Mr. Ard's oral remarks.

Additional Indiana Data

IMPACT OF PROJECT SAFE ON FIXED-INCOME HOUSEHOLDS

Indiana's Project SAFE assists the poor, elderly and disabled meet their fuel bills. Project SAFE is almost totally funded by LIHEAP appropriations. The data clearly contradict the administration rationalization for reducing the LIHEAP authorization. The percent of monthly income for heating cited by the administration is substantially less than the Indiana experience. The attached Exhibit A is from the Indiana Department of Human Services 1988 analysis of Project SAFE.

EFFECT ON NUMBER OF HOUSEHOLDS SERVED AND BENEFIT LEVEL UNDER PROJECT SAFE

Attached as Exhibit B is Mr. Ard's calculation of the effect reduced LIHEAP funding will have on the number of households served by Indiana's Project SAFE. If the LIHEAP appropriation is reduced to the level recommended by the administration, the number of households served must be reduced by 51,179 from the FY 1989 level if the same benefit level, adjusted for the absence of oil overcharge funds in FY 1990, is maintained. If the same number of households are to be served, the benefit level, again adjusted for the absence of oil overcharge funds in FY 1990, must be reduced by 38 percent.

The National Perspective

STABLE FUEL PRICES DO NOT REDUCE THE NEED FOR ADEQUATE LIHEAP FUNDING

The administration has asserted that energy prices are stabilizing, thus lessening the need for federal fuel assistance. Fuel prices have stabilized as compared to fuel costs prevailing at the time LIHEAP was created. However, this overlooks the fact that LIHEAP recipients still spend an unduly large portion of family income for energy. Studies have repeatedly shown that low-income families pay a much greater share of their incomes for energy costs than do other families. According to the most recent Department of Health and Human Services (HHS) Report to Congress on LIHEAP (covering the years through 1987), households with incomes below 125 percent of the poverty level spend approximately four times the amount of their income (13.2 percent) for energy than the remainder of American households (3.4 percent). The Indiana experience certainly confirms this.

Presently, only a small portion of these consumers' total energy costs is covered by LIHEAP. In its 1988 report, the Northeast Midwest Coalition indicated that for 1987, LIHEAP funds covered only 19.5 percent of the energy costs for eligible households. Moreover, according to statistics provided by HHS, only from 28 to 38 percent of all eligible households received LIHEAP funds in FY86. The average LIHEAP benefit is about $200 a year, versus about $1,000 in energy costs.

A.G.A. recently conducted a phone poll of state LIHEAP administrators, with responses covering programs in 45 states. The responses show that the majority of states do not supplement LIHEAP with state or local energy assistance funds and we are concerned about this. More than half of the respondents anticipated a shortfall of LIHEAP funding in their states during the 1988-1989 heating season. While 18 states were identified as not expecting a shortfall of funds for the 1988-1989 heating season, some of the reasons given lend additional support for increased LIHEAP funding: 5 respondents (Colorado, Delaware, Florida, Idaho and Michigan) indicated their states were going to cut benefits; 4 states (Hawaii, Kansas, Louisiana and Maine) would see their programs reaching fewer applicants; and 2 other states (Massachusetts and Wisconsin) planned to initiate other unspecified program changes in response to reductions in federal LIHEAP funding.

We also must emphasize that part of the recent fuel price stability is due to the level of fuel consumption, which directly corelates with the relatively mild winters we have experienced during the last two heating seasons. Congress should recognize that a return to normal or below normal weather next year would lead to increased fuel consumption which, in turn, would cause an increase in the percent of income devoted to home heating.

CONCLUSION

For the reasons stated in our May 3 testimony as well as the reasons set forth above, we urge that you recognize LIHEAP as a badly needed safety net for this nation's disadvantaged. We urge you to approve a funding level of $1.44 billion for FY90.

Respectfully submitted,

Mike Baly

Michael Baly III

THE IMPACT OF PROJECT SAFE
ON FIXED INCOME HOUSEHOLDS

Earlier sections of this analysis have clearly demonstrated that federal funding for Project SAFE has been in sharp decline since 1983.

The shrinking federal dollars have caused the Indiana Department of Human Services to re-examine the Project SAFE program procedures and the present delivery of service system. A random sample of FY 1988 Project SAFE households on fixed incomes was surveyed to determine what percentage of their monthly income was spent on home heating and what impact Project SAFE made on their winter heating costs. Fixed income households were chosen because they are "categorically eligible" for Project SAFE and their incomes' generally do not keep pace with the Consumer Price Index and inflation. The profiles of the random sample are as follows:

A. Group: Elderly (Age 60 and above)
   Household Size: 2
   Source of Income: Social Security
   Monthly Heating Cost: $80.00
   % of Monthly Income: 14
   % Paid by Project SAFE: 8

B. Group: Disabled (Age 59 and under)
   Household Size: 3
   Source of Income: (SSI/VA)
   Monthly Heating Cost: $83.00
   % of Monthly Income: 19
   % Paid by Project SAFE: 9

C. Group: Female (Age 59 and under)
   Household Size: 1
   Source of Income: Survivors Benefits (SSI)
   Monthly Heating Cost: $76.00
   % of Monthly Income: 21
   % Paid by Project SAFE: 10

D. Group: Single Mother (Age 59 and under)
   Household Size: 3-6
   Source of Income: AFDC
   Monthly Heating Cost: $104.00
   % of Monthly Income: 27
   % Paid by Project SAFE: 11

The following graph illustrates that the Single Mother and the Single Female receiving SSI are the most vulnerable to the cost of winter heating. One can assume certain socio-economic factors have a great impact on the size of their monthly heating costs, (e.g. substandard housing, lack of employment skills, poor education etc.) The energy burden for the two aforementioned groups tends to manifest and result in disconnection of service. While these groups do not constitute the majority of Emergency SAFE recipients, they tend to have pre-program utility arrearages that can run into thousands of dollars.

The Elderly and Disabled groups far much better than the aforementioned AFDC and SSI groups. However, these groups tend to require more usage to stay warm and specifically have much higher medical costs that depletes their monthly income.

Future Project SAFE programs will begin to address these needs and further target higher benefits to those who are the most vulnerable.

Exhibit A

THE IMPACT OF PROJECT SAFE ON FIXED INCOME HOUSEHOLDS

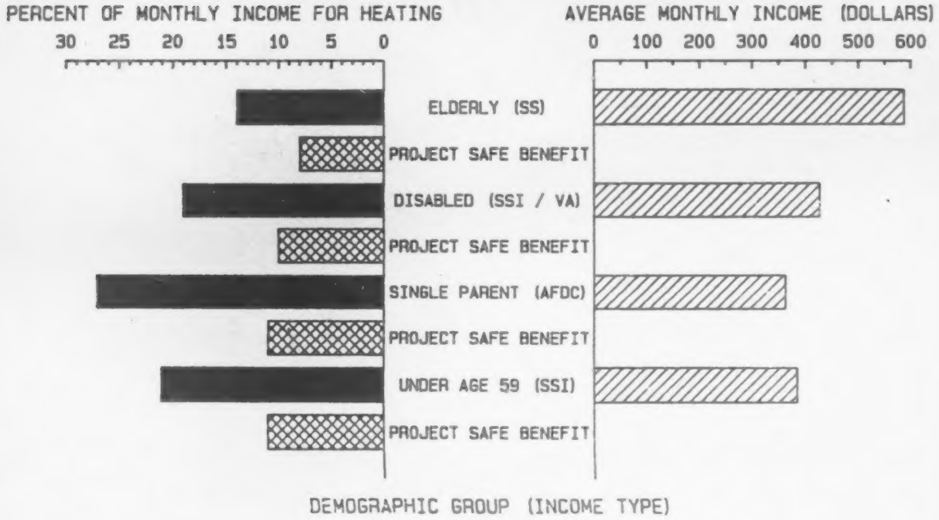
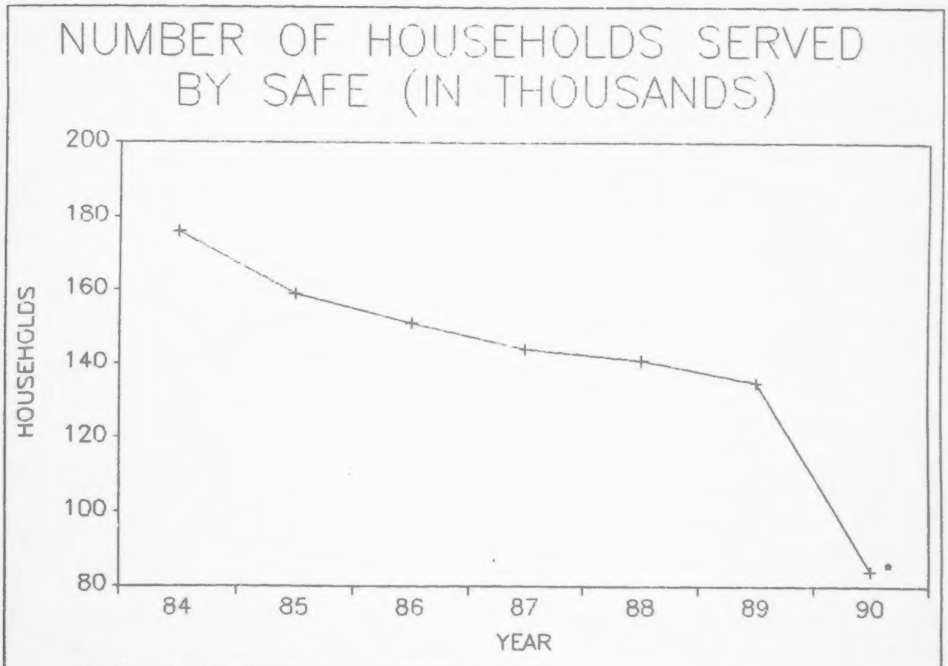


Exhibit B



* Estimate based on the Bush administration budget.

RAW DATA ON BACK.

Exhibit B

Project SAFE
Federal Allocation
FY 1984 - FY 1990

FY 1984

Federal Appropriation: $61,185,301
Households Served: 175,861

FY 1985

Federal Appropriation: $57,118,181
Households Served: 159,286

FY 1986

Federal Appropriation: $56,544,910*
Households Served: 151,271

FY 1987

Federal Appropriation: $47,860,555
Households Served: 143,975

FY 1988

Federal Appropriation: $40,219,607
Households Served: 141,488

FY 1989

Federal Appropriation: $36,323,914
Households Served: 135,276

FY 1990**

Federal Appropriation: $28,929,316
Households Served: 84,097

*Includes a 4.3% reduction due to Gramm-Rudman.
**Estimate based on the Administrations budget.

STATEMENT OF JOYCE PHILIBOSIAN STEIN, ARMENIAN EVANGELICAL SOCIAL SERVICE CENTER

The Armenian Evangelical Social Service Center has been working with Armenian immigrants and refugees in Los Angeles for the past eleven years. In recent years, we have been able to reach out effectively to the people we assist with English language (ESL) training, job development and placement, family counseling, and other transitional services because of the availability of federal funding. If these funding levels do not keep pace with the growing population of Armenian newcomers, or is reduced, the families we serve will suffer hardship as they face the substantial challenge of rebuilding their lives in their new country.

We recognize the teaching and leadership role of the Armenian-American community, and are cognizant of our responsibility to do our utmost to welcome and assist Armenian refugees and emigres who are admitted to the United States. At the same time, we are realistic about the constraints imposed by our very limited community resources. These resources have been strained way beyond capacity as we attempt to respond to the devastating December earthquake which struck Armenia. We feel strongly that full federal funding for those persons admitted as refugees is essential, and affirm the broader principal that policy commitments by the U.S. government to admit specific groups of persons to our country must be followed with program commitments and sufficient resources to enable their resettlement and early progress to self-sufficiency in our towns and communities. This is specifically true with regard to the large numbers of Soviet Armenians who, unable to qualify as refugees, are now being admitted as "parolees" by the Administration. If the Administration wishes to admit these and other persons as "parolees", it must provide the resources to enable their resettlement and adjustment to life in the U.S. The Administration must not carry out its foreign policy objectives on the backs of the states and counties, who are burdened already by repeatedly reduced periods of federal reimbursement for assistance to refugees.

Our recent emigres and refugees from the Soviet Union and the Middle East arrive here with great expectations, yet apprehensive about the great challenges they face. These newcomers:

1. Often do not have the opportunity to be in camps for months and years like other refugees, and to prepare for acculturation to the American way of life. They are suddenly taken from one culture and a totalitarian regime to an entirely different culture and the freedoms of the United States.

2. Come from societies of mistrust and need careful orientation to adjust to the rules, laws, and customs of our open society and to learn to trust and cooperate with us.

3. Are often shocked when they find they cannot seek employment unless they can communicate in English.

4. Are willing to work menial jobs for minimum wage, but are terrified of the loss of medical assistance, the high cost of medical care being prohibitive.

5. Are spending most of their income, or using most of their public assistance checks, on rent in the Hollywood area, where the recent Armenian emigre community is located and where most of their relatives live. In this downtown area essential facilities such as shopping areas and medical centers are within walking distance, or accessible by public transportation.

The majority of Armenians arriving from Soviet Armenia and the Middle East, mainly Iran, are skilled workers or professionals who cannot utilize their skills because of the language barrier. We must work with these new arrivals and guide and support them so that they may quickly become independent and self-supporting members of our communities. It is up to us, the Armenian-American community, and the federal and state and local governments, to work together to help them learn to stand on their own two feet. The understanding of their ethnic American community and sufficient federal funding work together to accomplish this task.

The following summaries briefly describe typical recent arrivals:

> Raffik, a refugee from Iran, came to Los Angeles with his wife during the summer of 1987. Upon graduation we placed him at the Discount Tire Center in Tarzana as a tire changer. He saved his earnings, and gradually purchased his own tools and learned to become a mechanic. He worked for minimum wage and a commission.
>
> After two years he is now the proud owner of his own Tire Center in Glendale.
>
> Rosa, a physicist who emigrated from Soviet Armenia who had worked with the famous Soviet scientist Alejhanian, attended our ESL classes in 1986. After graduation she sought employment and was placed with a telecommunications company in Los Angeles as an electronics engineer,
>
> Students Noriar and Anahid lost their only child, age four years, of a rare blood disease. They were hesitant in taking the child to the hospital because of their fear of an unknown culture and their unfamiliarity with the American medical system. Norair was on the verge of a nervous breakdown, but with support, counseling, and encouragement, both husband and wife recovered from this tragedy, completed their studies, and are now in the working world.

Petik, age 35, from Soviet Armenia, was having a difficult time raising his three sons, ages 6, 10, and 16. His wife had passed away a year earlier. They were being evicted. The police came and locked up their apartment and they had nowhere to go and had exhausted their savings. Our Center was able to get public assistance for this father and his children in order to pay for a hotel for a few days. In that time we were able to find them housing in an apartment at a reasonable rate.

Vartan, 53 years old, came to America from Soviet Armenia with his wife and two sons, daughter-in-law, and grandchild. Because they were not persecuted in Soviet Armenia they did not qualify as refugees, but were given parole status, yet not told of the implications. He did not have his I-94, which we helped him and his family to obtain. He was then able to get AFDC and after a while found a job. He is now able to provide for his family. He is very worried, however, by the fact that his immigration status is and will remain in limbo, as a parolee not having the right to become a permanent resident and eventually a U.S. citizen.

These are but a few examples of the problems that we face and the successes that we achieve each day. The important work that we do, as briefly described in the stories of these families, is ultimately dependent on our being given the resources necessary to do this work.

STATEMENT OF LAWRENCE T. SMEDLEY, NATIONAL COUNCIL OF SENIOR CITIZENS

The National Council of Senior Citizens (NCSC) appreciates this opportunity to provide our comments to the Senate Appropriations Subcommittee on Labor, Health, Human Services and Education. The National Council of Senior Citizens, founded in 1961 in the fight for Medicare, is an organization of more than four and one-half million senior activists in over 4,800 affiliated local clubs, Area Councils and State Councils.

Together, NCSC members work for state and Federal legislation to benefit the elderly and advocate senior citizens' interests in communities across the United States.

The National Council of Senior Citizens is disturbed by the Administration's proposal to cut funding for the Low-Income Home Energy Assistance Program (LIHEAP). This life-saving program provides households at or below 150 percent of the poverty level with some assistance in meeting with the costs of residential heating and cooling. Additionally, about 15 percent of the funds are used for energy conservation improvement to clients' homes. The average payment is only roughly $200.

As over a third of the persons receiving assistance from LIHEAP are over age 60, this program is particularly important for the health and economic security of America's elderly. The low-income elderly, who frequently live alone on fixed incomes and in older, less energy-efficient housing, must spend 18 percent of their income on energy. Further, unpaid energy bills can be a major cause of eviction of renters. Landlords in many cities are forbidden to rent units whose utilities are disconnected. LIHEAP is therefore an important program in preventing homelessness. For homeowners, unpaid bills can mean frozen pipes which cause expensive damages to house and furnace that cannot be repaired at affordable cost.

Moreover, the elderly are particularly at risk for hypothermia--a life-threatening condition caused by prolonged exposure to low temperatures--so that lowering thermostats to save on energy costs may present a severe health risk for seniors.

Since FY '85, LIHEAP has been cut by over a third. This year, the Administration is proposing a further cut to $1.1 billion, $283 million less than last year. While NCSC recognizes that, from a budget standpoint, these are difficult times, we feel it is unfair for this valuable program to again have to suffer a decrease in funding after having been cut so severely.

We urge the Committee, at a minimum, to fund LIHEAP at current services level ($1.44 billion) and, if possible, to take steps towards restoring it to its full authorization level. It is a discomforting thought for us at NCSC to think of America's elderly, after a lifetime of contributions and productivity to this country, shivering in their homes because they cannot afford heating or having their health endangered due to a lack of cooling assistance. It should be noted that, during FY '88, 30,000 fewer persons received cooling assistance. For the elderly, this can be a matter of life or death.

There is no program under the Older Americans Act with which the National Council of Senior Citizens is more familiar or more proud than Title V--the Senior Community Services Employment Program (SCSEP). As you know, the National Council has been a sponsor of Title V, which we call the Senior AIDES Program, since its inception in 1968. The expansion of Title V over the past two decades reflects the program's tremendous popularity and importance in towns and cities across the country and its unparalleled bipartisan support here in Washington. Every independent study of the program has concluded that Title V is meeting vital needs in the nation; that it is cost-effective; and that it is well managed and operated by the Department of Labor, the national contractors and the states. It would be very hard to find another Federal program that has received such positive and consistent comments after repeated studies.

We are all aware that Federal, state and local human service budgets have suffered severe cutbacks during the past several years. In many cities and counties, the only resource available to maintain vital services or to initiate needed new services has been through the help of Title V participants. Senior Aides have always worked in child and adult day care centers, in libraries, and in nutrition programs. In recent years, however, we have seen Senior Aides also working in shelters for the homeless, in centers caring for abused children, in food banks aiding disadvantaged people of all ages, and in soup kitchens providing hot meals for street people.

Recently, Title V received a modest increase in the unit cost, from $5,111 to $5225 to compensate for rising operating cost, Social Security payroll taxes and other expenses. However, this increase does not cover the increased costs due to recently revised state minimum wage rates. We believe that all Americans working at the minimum wage deserve a salary increase, and Title V senior workers, faced with escalating health care costs, rent, food and home energy bills are no exception. However, to raise the minimum wage without increasing funding forces SCSE programs to reduce the number of enrollees, as has already been the case already in those states which have raised the minimum wage. Therefore, we urge that the Committee appropriate additional funds in line with the expected increases in Federal and state minimum wage laws.

On another subject under the jurisdiction of the Subcommittee, NCSC is also concerned with funding for effective outreach under Section 155 of the Older Americans Act (OAA). The Supplemental Security Income program (SSI) is designed to ensure the economic security of the most vulnerable in society, the blind, disabled and aged, yet only half of the persons eligible are receiving benefits. This leaves two million elderly individuals living in poverty while they could be receiving benefits. According to a Lou Harris study of SSI eligible but non-participating persons aged 65 or over, 55 percent had never heard of the program and 62 percent did not know of or were not able to go to the application site. Funding of Section 155 of the Act would assure grants of at least $50,000 to each state. States could then, in turn, distribute these funds to Area Agencies on Aging based on the number of older persons in greatest economic need and the adequacy of existing outreach in each area. Funding Section 155 will allow for personal contact, such as helping a low-income widow to fill out an application for SSI or arranging for transportation for a frail older person to the Social Security office. It will help assure that the assistance under these programs goes to the persons whom Congress intended to protect.

Outreach efforts by the Federal government has been non-existent or else has been linked to general notices and announcemts in government mailings. Funding for SSI outreach is especially important since it was not funded in FY '89. At a small cost, it will benefit thousands of aged poor people for whom isolation and lack of information are barriers to subsistence benefits. We would ask that the Committee fund SSI outreach at its full ten-million-dollar authorization.

We thank the Committee for this opportunity to present our views.

STATEMENT OF PAUL FRIEDMAN, M.D., ASSOCIATION OF PROGRAM DIRECTORS IN SURGERY

We are pleased to have the opportunity to present testimony on FY 90 budget for Medicare, and particularly for projected Part A expenditures for indirect and direct medical education payments.

Introduction

The Association of Program Directors in Surgery (APDS) is comprised of all directors of accredited surgical training programs in the United States. The purpose of the Association is to provide the directors the opportunity to discuss their programs and to enhance surgical training of young physicians. Semiannual meetings and educational forums are held to continually update these directors about clinical skills, knowledge and commitment to excellence. In addition to providing didactic instruction in the complexities of the profession, emphasis is placed on the basic need for the young surgeon to assume responsibility for compassionate and dedicated care of patients.

The FY 90 budget for direct and indirect medical education payments under Medicare should remain intact, and should not be cut. The atmosphere created by the ongoing budget process this year has been unsettling, to say the least. In January, the Reagan Administration's final budget proposal proposed that indirect medical education payments should be cut almost in half, from 7.7% to 4.05%, or $1.02 billion. Additionally, the final Reagan budget proposed that direct medical education overhead reimbursements should also be reduced $150 million by excluding classroom space and teacher/professor reimbursement.

In February, the Bush budget proposed total Medicare cuts of $5.5 billion. However, $4.0 billion of that was to come from Part A, the major portion being slated for still deeper cuts, this time totalling $2.3 billion, in the indirect teaching adjustment. Earlier this month, the President joined with House and Senate leadership in announcing a Bipartisan Budget Agreement that would include $2.7 billion in overall Medicare cuts. It is unclear to us at this point how much of this is targeted for Part A in general, and to indirect and direct medical education payments in particular.

There is no doubt that in these difficult fiscal times, government must consider possible economies in all programs. Given the growth in Medicare that has substantially exceeded inflation, it is doubtless going to be a prime target. However, a substantial component of the sustained increases in costs over the last several years has been the largely uncontrollable growth in the number of potential beneficiaries. Even if there are to be cuts in Medicare, we urge you to assure that these not be drawn from indirect and direct medical education payments, which constitute our country's investment in the future physicians, and more importantly to the future quality of health care available to our citizens.

There are other ways to cut the federal government's health care bill that offer more promise than cuts to indirect and direct medical education payments. If the Congress could arrive at a comprehensive solution to the malpractice problem the spiralling costs of defensive medicine--where additional testing is undertaken, more to protect against a possible lawsuit than to confirm a diagnosis or treatment--

could be eliminated. Estimates of the financial impact of these unnecessary services vary up to a third of the total costs of health care, or two hundred billion dollars per year.

Inappropriate, excessive utilization of some procedures is also an area where substantial savings could be derived. The answer will not be easy, and we do not believe that efforts to shift to physician-administered rationing through expenditure targets or caps is the way to do so. However, there are already programs underway, and being scrutinized by the Health Subcommittee of Energy and Commerce to develop reliable medical guidelines against which utilization of procedures could be measured.

These areas for federal efforts are much more appropriate than cutting back on medical education, not only because they would focus on waste, but also because the potential volume of savings would be much more substantial.

Hospitals generally, and teaching institutions in particular already shoulder a substantial burden in trying to simultaneously help balance the federal budget while providing at least the minimal level of patient care needed by the sick and infirm. DRGs frequently create situations where hospitals must "cover" the costs of patients far in excess of the level of federal reimbursement. The Physician Payment Review Commission now estimates that 10 percent of all patients are cared for on a chariaty basis, with another 9 percent having fees eventually written off as bad debt--in short, a full 20% of the public is receiving care at the hospital's expense. Presently, it is the hospitals, particularly urban teaching institutions that are providing the pro bono care for a large portion of the 37 million Americans without health insurance.

This is a time when medical school applications have dropped precipitously, when the percentage of applicants who gain admission to medical school has dropped from 1 in 10 to 1 in 2. The number of medical school students choosing residencies in certain specialties, particularly family practice, internal medicine, and to a lesser extent, general surgery, indicates the likelihood of significant shortages in these specialties, if the current trends continue for very much longer. It is not the time to diminish in any manner our commitment to providing the finest education possible to our medical students and residents.

We urge you to hold fast to our Nation's commitment to the highest quality of medical care, now and for future generations. We hope that your Committee will understand the importance of a consistent, unwavering level of support in this process, and that the FY 90 budget allocations for indirect and direct medical education payments will remain stable and reliable in this and future years.

We appreciate the opportunity to present this testimony and would be pleased to respond to any questions.

STATEMENT OF ARTHUR LIFSON, VICE PRESIDENT, EQUICOR, INC.

Mr. Chairman, members of the committee, I am Arthur Lifson, Vice President of the EQUICOR Inc, a joint venture of the Equitable Life Assurance Society of the United States and Hospital Corporation of America. We are in the managed employee benefits business and are the fifth largest group health insurance company in the United States.

My remarks today represent the perspective of a private insurance company which has served the Medicare program as a Part B carrier since its inception in 1966. I also serve as the current chairman of the Medicare Administration Committee of the Health Insurance Association of America, the principal trade association for the private health insurance industry. In all, there are eight commercial insurance companies who help administer the Medicare program[1].

In the past few years, the Administration and Congress have cooperated to secure sufficient funds to assure that Medicare claims are processed accurately and on a timely basis. After all, this is the Medicare contractors most critical task. Breakdowns in basic claims processing would put the entire program in peril.

Mr. Natcher, before I comment on the proposed FY 1990 budget for Medicare contractors, I'd like to call your attention to a problem in the FY 1989 budget. In last year's appropriation, the Congress decided to place $100 million into a contingency fund to be available for use by the Medicare contractors in the event of unanticipated claims workload increases and other unforeseeable expenses. Back in January HCFA management concluded that FY 1989 claims volume was indeed greater than expected and that the costs of implementing the myriad Congressionally mandated activities affecting contractor costs would require additional funding. HCFA's request for the release of the contingency was sent to the Office of Management and Budget several months ago. The months are passing with no response from OMB. No additional funds appear forthcoming. We will soon be entering a critical stage in the annual funding cycle where contractors will have to reduce activities to match available resources. Because I fear the possibility of serious impairment in routine claims processing activities including the timely handling of claims payment, I request that the subcommittee look into this matter.

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[1] _/The following HIAA member companies help administer Medicare as carriers and/or intermediaries: Aetna Life & Casualty, EQUICOR, General American Life Insurance Company, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, Transamerica Occidental Life Insurance Company, Cooperativa de Seguros de Vida de Puerto Rico, and The Travelers Insurance Company. Each contractor has served the Medicare program since its inception in 1966.

After reviewing the President's FY 1990 budget for Medicare administration, as outlined in the documents HCFA has supplied to the Congress, it appears to us that adequate funds are being sought for basic claims processing functions. With several provisos which I will explain later, we think we will be able to process the claims workload increases we expect in 1990 with the funds requested.

However, the issue we wish to raise with you today goes to a more controversial point--the relative value of the Medicare contractors' role in protecting the integrity of the Medicare trust funds.

The President's budget submission for FY 1990 for Medicare administration contains $134 million less than the contractors are currently spending on Medicare program safeguard activities.

If implemented as proposed in the Administration's FY 1990 budget, payments to Medicare carriers and intermediaries for their payment safeguard activities would be reduced in the following amounts:

Part A	Hospital Audits	-49.9%
Part A	Medical Review	-41%
Part B	Medical Review	-21.5%
Part A	Medicare Secondary Payor	+9.1%
Part B	Medicare Secondary	-65.4%

The Health Care Financing Administration is acknowledging an anticipated loss of $1.138 billion from the Medicare Trust Funds as a result of the $134 million cut in contractor payment safeguard funding. This is simply astounding. If the old adage, "penny wise and pound foolish" has any basis in reality, these proposed cuts elevate it to the level of a "truth".

Medicare contractors will loose some income and the services of some very experienced employees. Those losses pale in comparison to the absolute waste of hard earned taxpayers' dollars. At a time when "every million" counts, the waste of over a billion of trust fund monies borders on the criminal.

On the whole, the Congress has done what it can legislatively to provide the statutory authority for the detection, investigation and prosecution of criminal fraud or abuse in these public programs.

While the Congress can pass tougher laws, it cannot implement them. Even the best statute or regulation is worthless unless those with responsibility for protecting the program have the means to do so. That responsibility starts with the Medicare claims processors. Unfortunately, our ability as Medicare contractors to patrol costly program misuse, waste and abuse, is a function of the resources made available to us.

Unfortunately, much of our story cannot be documented in dollars and cents. Hence, our problem with OMB, the Gramm-Rudman-Hollings Act and the Congressional Budget Committee scoring processes.

If a contractor employs aggressive, highly skilled individuals to ferret out mistakes and abusive billing by providers, and acts to nip them in the bud, there is presently no agreed upon way to document the ultimate savings to the program.

HCFA's present system for scoring medical review savings only captures those dollars which derive from prepayment claims denials or reductions and those post payment activities that recover inappropriate payments. On these activities, EQUICOR regularly returns more than nine dollars for every dollar spent!

For example, in 1988 EQUICOR charged Medicare $714,919 for the costs of prepayment medical review in Tennessee. This investment returned $7.1 million in real savings for a cost benefit ratio of 1/9.9.

Our postpayment review activities cost Medicare $381,081 and produced $284,809 in recoveries to the program, so we reported 1/.75 ratio. However, the true value of postpayment review activities such as provider education on proper billing procedures and Medicare acceptable practice patterns probably prevented millions of dollars in bills we didn't see and millions of dollars in bills we didn't have to reduce or deny.

EQUICOR also received $929,100 in 1988 from HCFA to pursue bills to Medicare which should have been paid by other insurers. With this activity, we returned $11,180,368 for a 1/11 cost benefit ratio.

I am sure you are aware of the Justice Department's claim that many billions of dollars were paid to hospitals and doctors when private employers and insurers should have paid on a primary basis for the so called "working aged". Since the issue is now before the courts, I merely wish to say that this is an area where inadequate budgets for carriers and intermediaries since 1982 has meant billions in lost recoveries for the Medicare trust funds. For example, HCFA should have allocated more funds for carriers and intermediaries to train hospital admitting clerks and physician's secretaries to ask about other coverage, to identify primary payers and recover misdirected payments.

Furthermore, much of the annual savings in the Medicare program attributed to the detection of fraud and abuse by the Inspector General's Office were actually made possible by carrier and intermediary medical review and audit activities. If contractor funds for program safeguard activities are slashed, the Inspector General's Office will not get as many case referrals and will see fewer recommendations for special studies. There is no doubt in my mind that the IG's effectiveness will also be diminished.

No question it's more difficult to document the savings that result from the dollars spent on educating and monitoring providers, However, the sentinel effect which a vigorous claims review operation will produce is real!

I am concerned about the consequences this budget decision would have on our ability to continue to employ adequate numbers of qualified medical review and program integrity staff. While we would naturally strive to retain our best performing employees, we believe many of them would seek other employment. Our medical review staff are professionals with skills that are in high demand in the medical marketplace. They will most likely find employment with the hospitals, doctors and suppliers they have been monitoring. Should these talented individuals leave us, we will likely have to replace them with less experienced staff. As a consequence, we expect the quality of our work to also suffer.

At EQUICOR, we estimate we will have to eliminate 84 positions, nearly half of which are in our medical review area. This equates to the following staff reductions to meet FY 90's level of funding:

Part B Medical Review:	-25%
Part B MSP:	-60%

These reductions, in turn, will surely jeopardize our ability to detect, monitor, and recoup Medicare outlays.

Mr. Chairman, my primary objective today is to call your attention to the proposed cuts in Medicare program safeguard activities. However, the committee should also be aware that Medicare contractors are currently in the process of implementing some important new projects that should add to our capacity to do quality medical review. Effective April 1 carriers are coding the medical diagnosis on all claims. Carriers are also coding the unique identification numbers of all physicians ordering tests, equipment, and other services. With this information, HCFA will now be able to look at physician practice patterns and their impact on Medicare expenditures.

In 1990 HCFA also hopes to operate a number of common working file sites which will make it possible for us to track total Medicare expenditures per beneficiary. While each of these projects will provide valuable new information with which to better manage the Medicare program, each represents a costly investment in equipment and personnel. In the short run, at least, they are costly new initiatives for which adequate funding is not yet assured. We trust this committee will consider these investments in program improvements when deciding on an appropriation figure for Medicare contractor activities.

Conclusion

Mr. Chairman, it's our judgement that contractors need at least $250 million above the mark contained in the President's budget request in order to continue our present level of Medicare program safeguard activities and maintain the integrity of the Medicare Trust Fund. That $250 million would restore program safeguards to the FY 1989 level plus provide for inflation and claims growth. With these funds, contractors will save at least $1.8 billion more than the savings projected in the President's budget.

The following table describes the proposed FY 1990 budget and the anticipated savings resulting from contractor payment safeguard activities.

Attachment 1

Administration's FY 1990 Budget for Program Safeguard Costs and Projected Savings*
(in millions)

	FY 1989		FY 1990			
	Admin. Costs	Savings	Admin. Costs		Savings	
Medical Review/ Utilization Review						
Part A	$ 62.9	$ 230.2	$ 36.8	(-26.1)	$ 134.7	(- 95.5)
Part B	99.1	693.7	77.8	(-21.3)	544.6	(-149.1)
Audit						
Part A	133.0	820.0	66.7	(-66.3)	59.4	(-760.6)
Medicare Secondary Payer						
Part A	32.6	1,016.9	35.7	(+3.1)	1,100.0	(+ 84.0)
Part B	35.5	291.0	12.3	(-23.2)	75.0	(-216.0)
Total	$363.1	$3,051.8	$229.3	(-133.8)	$1,913.7	(-1,138.1)

* From "Justifications of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1990, US. Department of Health & Human Services, HCFA, Page 61.

STATEMENT OF FRED D. HIRT, PRESIDENT, MOUNT SINAI MEDICAL CENTER OF GREATER MIAMI

Mr. Chairman and Members of the Subcommittee, thank you very much for the opportunity to present testimony on an important demonstration program, authorized by the Congress through the Omnibus Reconciliation Act of 1986, and administered by the Health Care Financing Administration. I would like to discuss the overall value of the program and the individual merits of a proposal that Mount Sinai Medical Center of Miami has submitted to HCFA for participation in this pilot program.

HCFA has been given the opportunity to develop a project to test the feasibility and cost of possible Medicare coverage for community services for victims of Alzheimer's Disease or related disorders. HCFA is authorized to sponsor up to ten demonstration sites, each offering Alzheimer's victims and their families community-based support services that will be supervised and evaluated by case managers.

The program promises to be a useful public policy tool, as it will allow policymakers to assess the costs and benefits of policy changes before they are widely implemented. The provision of expanded care services under the case management model will offer policymakers the opportunity to study the effects of the services on Medicare costs, total health care expenditures, the deterioration in clients' functional and cognitive abilities, and the stress on family caregivers and their ability to continue to care for Alzheimer's patients at home as the disease progresses. The demonstration will also provide a forum for alternative management and financing approaches at sites located in geographically diverse areas in states with a high proportion of Medicare beneficiaries.

Mount Sinai Medical Center, in conjunction with the University of Miami, has applied to HCFA for designation as one of these demonstration sites. With our goal being to provide greater access to needed care for Alzheimer's patients and their families, we propose to coordinate community programs within a large three-county catchment area and develop intake sites, case management capabilities, and a service provider network. We further propose to work in concert with the Miami Jewish Home and Hospital for the Aged in order to implement the most comprehensive, effective program encompassing the Dade, Broward and Palm Beach counties.

A major strength of Mount Sinai's proposal is the cumulative experience of both Mount Sinai Medical Center, the University of Miami School of Medicine, and the other organizations involved in carrying out the proposal, in the provision of long-term care and elderly services. Because of the large geriatric population concentrated in the Greater Miami area, Mount Sinai has a special focus on the delivery of diagnosis, treatment, case management, and supportive services to patients with dementia and their caregivers.

Mount Sinai has developed several successful programs to meet the needs of its primary elderly patient population, and has attracted internationally recognized physicians with extensive experience in dementia to direct them. These programs include the Wien

Center for Alzheimer's Disease and Memory Disorders, a full-service outpatient diagnostic and treatment clinic for patients with memory loss; Home Advantage, a joint home health agency of Mount Sinai and the Miami Jewish Home and Hospital for the Aged; Mount Sinai Elder Care, a HCFA Medicaid Section 1115 (b) demonstration providing medical care and services for frail elderly people; the Medicaid Health Plan, a Medicaid health maintenance organization; and Project Sinai, a geriatric outpatient primary care clinic. In addition, Mount Sinai has a dedicated Section of Geriatric Medicine within the Department of Internal Medicine.

The Wien Center for Alzheimer's Disease and Memory Disorders is the cornerstone of Mount Sinai's geriatric programs. One of four state-designated memory disorders clinics under Florida's Alzheimer's Disease Initiative, the Wien Center has become the largest diagnostic and treatment program for memory disorders in Florida. The Center provides a multidisciplinary approach to memory disorders involving neurology, psychiatry, internal medicine, psychology, nursing and social work as well as state of the art diagnostic imaging technologies. The Wien Center, along with Mount Sinai's other programs for the elderly, particularly those for Medicaid patients, provide a strong foundation for conducting a HCFA demonstration. Indeed, Mount Sinai has been a participating provider of care to Medicare/Medicaid patients since the inception of the programs, and as such, its staff has extensive knowledge of Medicare and Medicaid regulations and billing procedures.

Mount Sinai Medical Center and the other joint applicants for this demonstration will provide in-home services, counseling, mental health services, and overnight and in-home respite services to patients in an expansive catchment area. The South Florida area provides a virtual laboratory for this demonstration, as it leads the nation in the proportion of persons over 65 in the population. In the three counties to be included in this demonstration alone, there are nearly 800,000 individuals 65 or over, representing 18% of the general population. Clearly this catchment area will include sufficient numbers of eligible persons for the demonstration, and it is only fitting that such a valuable demonstration be conducted in a region where the problem exists to such a large degree. To ensure an adequate participation of elderly persons in the demonstration, our proposal includes a coordinated media/public education campaign and other community outreach activities.

Training and education of both formal and informal caregivers and project staff will also be an important part of the demonstration. The University of Miami, through its Miami Area Geriatric Education Center, will be primarily responsible for developing and implementing education and training activities. The University will work closely with the training staff of Florida International University's Southeast Center on Aging, local ADRDA chapters and other agencies, as well as with Mount Sinai, in designing and delivering training.

The Mount Sinai proposal goes beyond fulfilling those criteria established by HCFA for demonstration sites by incorporating several significant, innovative approaches to providing care for dementia patients:

- Development of a tri-county network of case management and service delivery which offers nationwide replicability;
- Involvement of over fifty organizations in the aging network in the planning and implementation of a national demonstration;
- Use of one-on-one training for informal caregivers in the home and for formal caregivers in an institutional setting;
- Development of a multidisciplinary team approach in care planning using a Case Manager (social worker), Associate Area Director (nurse), physician, and other disciplines as appropriate; and

- Utilization of the existing State of Florida's Alzheimer's Disease Initiative program -- a network of well-functioning memory disorder clinics, day care, and respite programs -- in the delivery of service.

These special features of the Mount Sinai project, along with the hospital's outstanding qualifications to operate a demonstration program in a region with a high proportion of elderly persons, make our proposal an excellent candidate to carry out the mission created by Congress with this demonstration program. I urge your support for expanded funding for the HCFA demonstration sites so that Mount Sinai can participate, along with other institutions in the Miami area and around the country, in this worthy program that promises to ease the pain of those suffering from Alzheimer's Disease.

STATEMENT OF O. MILTON GOSSETT, NATIONAL CENTER FOR HEALTH EDUCATION

Mr. Chairman and members of the Committee, my name is Mr. Milt Gossett and I am a member of the Board of Directors of the National Center for Health Education. The overall objective of the Center is to improve the health of the American people through health education. The Center was founded at the direction of the President's Committee on Health Education, which issued its final report in 1973. Since our founding we have focused on the following: determining exactly what is being done now in health education; how well it is being done; how more can be done; and how what is done can be made to deliver results.

Specifically, today we will focus our remarks on the importance of comprehensive school health education in the United States. Comprehensive school health education is health education in a school setting that is planned and carried out with the purpose of maintaining, reinforcing or enhancing the health, health-related skills and health attitudes and practices of children and youth that are conducive to their health.

A recent national study shows that positive health behavior increases in direct proportion to the amount of time and coordination devoted to health instruction, and has a strong influence on children's attitudes and behavior towards substance abuse and other high risk behaviors (Journal of School Health, October, 1985). For example, less than 8% of seventh grade students who were taught health reported that they were smoking compared to more than 12% of the comparison classroom seventh graders. As a result, many of the nation's leading experts on health and disease, including the President's Commission on HIV infections, have identified comprehensive school health education to be the most effective solution in the fight against AIDS and substance abuse.

Status of Comprehensive School Health Education

Today, on average, out of the entire school day we are providing our children with only four minutes of health instruction. Equally disturbing is the quality of the health education our children receive. Please consider the following:

- Only fifteen percent of our nation's schools are employing a comprehensive school health education program at this time.
- Much of the education is single-focused. Although some is of great value, often the public is bombarded with information and left to its own devices to separate the reliable from the unreliable.
- Only 1/4 of one unit of credit is offered during the four years of school programs at the high school level. Many states have no health education requirement at all. This demonstrates the low regard with which school health education is held by some administrators and other school budget decision makers.
- Because of competing demands at the state and local level, school health programs and staff are often cut. As a

result, even when commitments are made to programs of this type, they are generally at a level below that prescribed by health education program developers.

This is occurring during a time in which the health needs of our nation are undergoing dramatic and life-threatening changes--from a time when teaching the four basic food groups was the foundation of health education to the present where drugs, AIDS, alcohol and tobacco abuse and school violence threaten the very nature of our educational system.

Goal: Provide all schools with comprehensive health education by the year 2000

The National Center for Health Education's goal is to provide all of America's schools with comprehensive school health education by the year 2000. For ten years we have worked with diligence and imagination to fulfill this mission. The federal government was instrumental in the development of one such curriculum--Growing Healthy, which is sponsored by the Center and is the only curriculum which has been validated by the U.S. Department of Education. There are two unique aspects to the Growing Healthy curriculum. One, the backbone of the program is teacher training. Secondly, because the subject matter is presented through a highly entertaining multi-media approach, students are more motivated and their reading, mathematics and science scores increase. The recently completed School Health Education Evaluation, independently conducted under the aegis of the Centers for Disease Control and the U.S. Office of Disease Prevention and Health Promotion, determined that Growing Healthy is a highly effective curriculum --students in schools using this curriculum were far less likely to have engaged in a number of high risk behaviors than students in comparison schools without such an educational program.

How to reach this Goal?

The National Center for Health Education is the leader in a growing movement to unite those people in the single field of "education for health" using that term to include all professionals and volunteers who educate others about health issues. Through the last ten years it has been demonstrated that education can provide Americans with tools for making healthful decisions, for taking better care of themselves and others as individuals, and for acting collectively to achieve higher levels of community health. In addition to the Growing Healthy curriculum, there are many others, all of which if implemented in our schools will have a positive influence on our nation's health.

Some feel that education is the sole responsibility of the states. However, as described above, the job is not getting done. Therefore, NCHE supports federal funding in the following areas:

- o Currently, all of the funding in the area of school health and administered by CDC is in the area of AIDS education. Therefore, we urge Congress to allocate $500,000 in non-AIDS funding at the Centers for Disease Control to allow for the dissemination of validated comprehensive school health curricula (kindergarten through twelfth grade).

- o establish funding at a level of $5 million to develop regional teacher training programs in the area of comprehensive school health (50 centers/$100,000). Through our experience with the Growing Health curriculum we have demonstrated a cost-effective teacher training methodology. We are certain that there are other as yet undiscovered approaches which may be tailored to rural areas, and other settings with unique needs. This program would be modeled after the existing regional teacher training programs administered by CDC in the area of AIDS education

- o increase the funding for the grant program within the Office of Comprehensive School Health Education in the Department of Education to $6 million in fiscal year 1990. Last year, the Augustus F. Hawkins-Robert T.Stafford Elementary and Secondary School Improvement Amendments of 1988 authorized the establishment of the Office of Comprehensive School Health Education within the Office of the Secretary. At the present time, the Education Department is drafting regulations to implement this law. We expect a grant program to the states will be created to assist with teacher training. We support this initiative. In addition, we recommend the Secretary be directed to establish, staff and operate the Office from administrative funds available within the Department. We also recommend that the Office be directed by a specialist in comprehensive school health to carry out its mandate.
- o provide $250,000 at the Office of Disease Prevention and Health Promotion to sponsor a National Congress on Health Education. The Congress would bring together key players from the public (Centers for Disease Control, Office of Disease Prevention and Health Promotion, Office of Comprehensive School Health and Office of National Drug Control Policy) and private sectors to set the nation's agenda for health education/health promotion during the next decade.

Summary

The health and fitness of America's young people is declining at an alarming rate. Two out of every three students have used illegal drugs. One out of every four has a serious alcohol problem. A study of more than 4 million children revealed that only one out of three could pass even the most basic standard test of fitness. What is the answer? Comprehensive school health education programs are designed to allow the student to develop increased skills over a period of years. Numerous studies have demonstrated this to be the most productive and cost effective method of health education. The Center is eager to work with our nation's leaders to implement this type of program in all of our schools by the year 2000. We would be pleased to answer any questions. Thank you for this opportunity to present our comments.

STATEMENT OF THE NATIONAL DEMOCRATIC POLICY COMMITTEE

Thank you, Mr. Chairman, for the opportunity to testify on the Labor, HHS, and Education budgets for fiscal year 1990.

The NDPC is profoundly concerned about the effects of many years of fiscal quackery for our nation's health care system, including the morally repugnant euthanasia movement which has resulted. The choice Congress faces is between upholding America's historic role in advancing traditional medicine, or continuing to allow the nation to submit to a monetarist dictatorship over health care.

This committee can contribute to the programmatic shift necessary to fulfill America's historic notion of progress, to develop an economic program based on science and technology that affords us greater capacity to impove health and longevity.

The alternative is an America, not unlike that of a third world colony, governed by monetarists that demand that the most fundamental precept of American society and government, the sacredness of individual human life, be sacrificed for a policy of fiscal austerity.

Under the federal government's guise of cost-containment, the science, education and practice of traditional medical care in this country has been systematically destroyed by budget cuts, managed health care schemes, and mandatory "quality of life" protocols that openly promote savings by not feeding patients. By one estimate, an outragous 15 to 25% of every dollar spent on health care annually in this country goes to "researching" new cost-containment scams. These funds are diverted from patient care and research.

While millions are spent on studies that claim it is not worth resuscitating elderly hospital patients, NASA produced an implantable defilibrator which can reduce mortality from cardiac arhythmia by a full 25%. It will save billions of dollars in medical care for the 400,000 people who suffer from cardiac arrest annually.

By contrast, the Office of Technology Assessment spent nearly a million in 1987 on a study entitled "Life-Sustaining Technologies and the Elderly." It developed non-treatment patient categories to be implemented according to the degree of rationing the government is willing to risk politically. The study aims to eliminate antibiotics, tube and intravenous feeding and hydration, cardiopulmonary resuscitation, renal dialysis, and mechanical ventilation, as "inappropriate treatment" for some patients. The point of this study was to revamp America's medical protocols so the treatment you receive is no longer governed by medical but fiscal criteria.

There are several other examples in just the last year. HCFA was sued by 14 congressmen stop killing people by illegally and repeatedly denying Medicare benefits to thousands of elderly for part-time home health care. Again, court intervention was needed to stop HCFA from slashing by 48% the in-home dialysis reimbursement rates which Medicare itself mandated five years earlier.

Behind the fallacy of cost-containment is the destruction of the health care delivery infrastructure--as Medicare's Prospective Payment System and its DRGs (Diagnosis Related Groups) has demonstrated. The DRG system so underpays hospitals that it is has been charged with causing patient dumping, premature discharge of elderly patients, and the nursing shortage. Because of DRGs, 2700 rural hospitals are threatened, and by 1992 as many as 700 hospitals are expected to go bankrupt along with the many people and small industries that make up the network supporting the medical community. Yet, the HCFA's William Roper and Glenn D. Hackbarth say "We could do just fine with fewer hospitals." The last time fiscal experts were given free reign to cannibalize a nation's infrastructure was under Hjalmer Schacht.

The same mentality is pervasive among insurers. Millions of health insurance company funds pay for programs that train physicians to think primarily about the "financial ramifications and cost-benefit equations" of their treatment decisions. Groups like Prudential, Blue Cross/Blue Shield, and the Robert Wood Johnson Foundation, fund programs like Oregon Health Decisions that use cost analysis of expenditures for seriously ill newborns, and comatose and terminally ill patients to manipulate community response patterns about how triage of these costly patients is the only "fair" solution with scarce resources.

Now these insurance companies are cited in a scam in which they knowingly had Medicare pay for at least $10 billion dollars of care for which they contracted to cover. HCFA's William Roper not only knew of this for six years, he contracted some of the same insurers to oversee Medicare disbursements!

The totally unregulated, unsupervised field of cost management companies is another area where hundreds of millions of health care dollars are diverted from patient care to profits for companies who "take a scalpel to health costs." They boast that "case management" of seriously ill patients with cancer or AIDS, or those recovering from stroke, can "save" $15,000 to "$400,000 a case." What does a patient give up to save a company $400,000?

Capitation is promoted as the core of all national health care proposals we see today. Sen. Ted Kennedy recognized this when he went to the New York-based Hastings Center in 1977 to discuss "what we can't talk about publicly, that is, denying health care to the sick under a system of national health insurance."

Research shows that stringent economic rate controls contribute to higher death rates, while the development of new lifesaving technology pays for itself and also saves lives--yet insurers refuse to cover it. At recent House Science, Space, and Technology Committee hearings, researchers presented the Programmable Implantable Medication System (PIMS) which is an implanted programmable infusion pump that delivers prescribed and precisely measured insulin doses or other medication. It could save billions, even possibly close to half, of the $20.37 billion annual medical and indirect costs (American Diabetes Association estimate-1987) of the two million diabetics. Despite these radical improvements and tremendous savings to the nation, the insurance companies refuse to cover it.

Thus, the nation is held hostage by the health insurance industry, utilization review firms, and cost-management companies. Our physicians, like those under the Nazi regime, have been ordered to subordinate the sacredness of life, and their Hippocratic oath, to dangerous and incompetent budgetary policy. While the economy shrinks, larger proportions of annual health care funds are consciously diverted from patient care. A few extra dollars in appropriations will do little to save a system that differs from Hitler's ravages only in degrees.

- NDPC Proposals -

1) At least $3 billion a year for an Apollo-style crash program of research in the area of optical biophysics to develop a cure for AIDS.

2) A construction program of hospital-bed facilities for handling the expected case-load of AIDS-infected persons requiring hospital care.

3) An immediate suspension of all cost-containment resesarch and consultants. Immediate removal of William Roper as head of HCFA.

4) A complete national assessment of the collapse of rural and urban hospitals and trauma centers.

5) A complete reinstatement of all monies needed for teaching hospitals.

6) Immediate regulation of the whole area of health cost-management companies, HMOs, and their variations. Insurance companies operating in the U.S. must be forced to open their books.

7) Economic policies that have America reclaim its productive and technological superiority.

STATEMENT OF JOSEPH H. KEFFER, M.D., AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

The American Society of Clinical Pathologists (ASCP) is a nonprofit medical society organized for educational and scientific purposes. Its membership consists of over 40,000 board certified pathologists, other physicians, clinical scientists and certified laboratory technologists and technicians. The ASCP is also the nation's principal source of continuing medical laboratory education, sponsoring over 400 educational programs a year. The ASCP's certifying board, the ASCP Board of Registry, registers over 140,000 laboratory professionals annually. Founded in 1928, it is the nation's oldest and largest certifying agency for laboratory professionals. As of February 1988 it had certified 279,104 laboratory professionals in 16 categories.

The ASCP urgently seeks Congressional support to address the current shortage of medical technologists and other allied health personnel. This shortage of qualified personnel affects the quality and timeliness of medical laboratory testing. A survey conducted for ASCP in late 1988 showed that an alarming percentage of positions in the nation's medical laboratories were unfilled. Conducted by Market Opinion Research Inc., an independent firm, the survey showed that 9.3% of medical technologist and 13.6% of cytotechnologist positions were vacant. This compares to the nursing vacancy rate of 11.3% cited by the American Hospital Association. In addition to the high level of vacant positions, more than three quarters of the laboratory managers surveyed in this study perceived a shortage of qualified laboratory personnel in their communities.

Medical technologists perform most of the nation's medical tests used for diagnosis, treatment, and prevention of disease. Cytotechnologists screen human cell samples, including pap smears, under the microscope looking for signs of cancer and other diseases. Both groups work with pathologists--physicians who specialize in laboratory medicine. Under this physician supervision, medical technologists perform most of the 5 billion laboratory tests conducted each year in the United States. The importance of accurate results in these tests can not be underestimated. Congress acted in 1988 to strengthen federal regulation of the quality of laboratory services. Manpower shortages mean that existing personnel are overworked with additional risk of error and harm to patients whose physicians are relying on these tests to assist in making a diagnosis.

The manpower shortage is made more acute by the number of accredited medical technologist schools that have closed. In 1982 there were 639 general medical technology programs. By the end of the 1988 program year, the number had declined to 464, a decline of 32 percent. Assuring quality laboratory services begins with a sound education program. If these programs are not maintained, the availability of well-trained laboratory personnel will decrease.

ASCP believes that two factors have caused this decline in training programs. One is that the federal government terminated its support for allied health programs in 1981. Second, cost pressures on hospitals have caused many of them to discontinue in-house educational programs, including those of medical technologists and cytotechnologists hoping to be able to employ personnel without the cost of educating them. Medical technologist training programs exist both at universities and also at hospitals. Often the hospital training program is the only source of competent laboratory staff available to rural communities. The demand for technologists will only increase because of changes in health care brought about by an aging population, increases in therapeutic drug monitoring, testing for substance abuse, and testing for AIDS. The Bureau of Labor Statistics projects by the year 2000 there will be 57,000 new jobs for clinical laboratory technologists. These positions will not be filled unless funding for education programs is made available quickly.

In 1988 Congress reinstated programs of support for allied health professions education and training, including education programs for medical technologists. Public Law 100-607 created a new program for allied health project grants for curriculum and faculty development as well as enhanced recruitment activities. Both hospital based educational programs and universities compete equally for funding under this program. The law also authorized $2 million for allied health student loan repayment programs for those students who work in rural hospitals, nursing homes, and the Indian Health Service. Finally the new manpower law authorized $2 million for student traineeships and doctoral programs to help develop new faculty.

The American Society of Clinical Pathologists urges the Subcommittee to support full appropriations for these three new allied health education programs. Each program should receive the full $2 million authorized under PL 100-607. The erosion of training programs and the continuing manpower shortage that threatens the quality of care must be quickly reversed. This effort can only be accomplished with adequate federal support. ASCP strongly urges the subcommittee to appropriate the full $2 million for each of the allied health education programs.

STATEMENT OF THE SUMMIT ON MANPOWER

The Summit on Manpower is a collaborative effort of 17 national health care organizations formed to address a common concern - the growing shortage of radiologic technologists and sonographers in the United States. Under the guidance of the

American Healthcare Radiology Administration (AHRA), representatives of the 17 organizations convened for the first meeting in April 1988 and held a follow-up meeting in November. This was the first time all the professional organizations, certifying boards, and educational accreditation boards representing the radiological sciences had met as a group to work on a common problem and set goals and objectives in an effort to find solutions to the manpower shortage.

Much of the Summit's initial work was directed at validating the widespread perception that a shortage of technologists and sonographers exists. While there was a great deal of anecdotal evidence pointing to a shortage, the nature and extent of the problem had to be documented. At the November meeting, a special Task Force on Data presented the results of its exhaustive review of available research and information.

In response to its documentation, the Summit organizations agreed upon a position and released a statement concluding that "existing data on manpower in radiography, sonography, nuclear medicine technology and radiation therapy technology indicate that the supply of qualified personnel does not meet current demand nor will it meet future needs. Further, the Summit is concerned that without active intervention, patient care and patient services will be compromised. The summit is committed to the development and implementation of action plans which focus on education, government relations, recruitment, and retention."

The Summit organizations representing approximately 300,000 professionals urge you to support appropriations for the funds for programs authorized in the Health Onmibus Extension Act (P.L. 100-607) enacted last year. Realizing that radiological science is only a small portion (10%) of all allied health in the United States, it is our belief that any assistance in support of education will benefit the profession and help minimize the dilemma we are now facing with the shortages of personnel.

The Summit's Task Force on Data reported on their review of existing data sources to substantiate the conclusion that a shortage does exist. Three types of organizations have data related to the issue: (1) organizations focusing on education; (2) organizations focusing on certification; and (3) organizations focusing on professional issues of which employment is one. Organizations involved in education have data from which supply of personnel for the near future can be assessed; those dealing with certification have data on the current supply of personnel. Several organizations from the third category provided survey data which linked current supply and demand. In addition two government studies were referenced that deal with projected future demand. Current supply information is based on certification data. The following are the numbers of certified technologists. (It is estimated that 20-30% of the working technologists are not certified.)

Radiographers	156,011	(70% in hospitals)
Nuclear Medicine	9,491	(90% in hospitals)
Radiation Therapy	5,751	(80% in hospitals)
Sonographers	12,550	(66% in hospitals)

Two nationwide surveys conducted in 1988 by the AHRH and the Society of Nuclear Medicine Technologists Section addressed the issue of current supply and demand of technologists. A deficit is noted in every case for which data were collected. Vacancy rates ranged from 3% to 15% in radiography, from 3% to 13% in nuclear medicine technology, from 5% to 21% in radiation therapy technology and from 4% to 17% in sonography. In two surveys, questions asking whether a shortage was thought to exist were included. Respondents to both surveys overwhelmingly felt that a lack of technologists existed. 84% perceived a shortage in radiography, 84% perceived a shortage in nuclear medicine technology, and 91% indicated a shortage in Sonography. The data collected imply that demand exceeds supply in the hospital sector, which in turn accounts for the majority of positions.

Furthermore, the data available indicates that the shortage is not isolated to specific regions of the country.

The future supply of technologists at the present time is dismal. Since 1985, there has been a 13% decrease in the number of educational programs in radiography and a 25% decrease in the number of nuclear medicine technology schools. Along with the loss in schools has been a marked decrease in the number of graduates. The schools are all running at less than their approved capacity. The schools for radiography are at 57% capacity, nuclear medicine at 63% capacity, radiation therapy 48% capacity, and sonography at 62% capacity. The number of individuals taking the certification boards also verify this decrease in future availability. The number of graduates taking the certifying boards in radiography from 1985 to 1988 decreased 18%, decreased 9% in radiation therapy, and 40% in nuclear medicine.

Two recent government studies dealt with manpower shortages in allied health. "Allied Health Services: Avoiding Crises" by the Institute of Medicine uses projections reported in "Employment by Occupation and Industry; 1986 and Projected 2000 Alternatives" by the Bureau of Labor Statistics (BLS). A growth rate of 65% is projected for radiologic technologists over a twelve-year period. The current rate of increase in radiologic technologists (about 4,000 to 5,000 per year) falls short of the roughly 6,000 per year needed to reach that projection. The decreasing number of examinees will further exacerbate the shortfall.

A major factor in the projected increased need for radiologic technologists is the aging of the U.S. population and the consequent increased health care required. A very significant problem in meeting manpower needs is the parallel aging of the technologist population. The largest percentage of the current technologist population was born in the 1950s. That means that just as the need for additional technologists is peaking, a large population will be preparing for retirement.

This trend has the potential to make the shortage extremely severe in the future. The Institute of Medicine report concludes that "early and significant action in this field is needed to forestall serious problems in the future delivery of health services."

A nation wide shortage of radiographers, nuclear medicine technologists, radiation therapy technologists, and sonographers currently exists. The scarcity of technologists is being felt in essentially all parts of the country based upon data collected in 1988. The shortages are predicted to become increasingly severe based upon the current trend in supply and the projected trend in demand. When government projections for increased demand and demographic trends suggesting decreased supply are considered, the potential for an extreme shortage exists in the near future for all the disciplines.

Please consider complete funding for allied health as authorized in P.L. 100-607. Although this will have a minor effect on the shortages occurring in our field, it is believed that this is a positive start in the right direction for adequate health care in the future. By providing complete appropriations for the allied health portion of the bill, the Committee will demonstrate its awareness of the existing problems in providing adequate education and training for students in allied health, including the radiological sciences, and in ultimately supporting quality health care.

STATEMENT OF ASM

The Administration request for $573,558,000 is $26,000,000 less than the fiscal year 1989 appropriation, and when inflation is factored in (4.2%), the difference is approximately $50,000,000. Admittedly, we note that significant resources are being allocated for the control of AIDS, and we welcome this continuing effort. However, we are extremely concerned about the looming neglect of other ares of disease control within the CDC.

The past several years the Administration has consistently refused to increase funds for project grants awarded to state and local government authorities to support programs in education, surveillance, testing, outbreak investigation, the control of sexually-transmitted disease such as chlamydia, syphilis, and gonorrhea. The rising number of syphilis cases is frightening. The number of cases rose from 27,000 (11.5%\1,000,000 population) in 1986 to 35,000 (14.6%\1,000,000 population) in 1987 and preliminary figures for 1988 show an additional increase to over 40,000 (16.7/1,000,000) reported cases (MMWR 37:802, 1988). The syphilis incidence has increased approximately 45% in just two years. The increase was greatest among Blacks and Hispanics. Tragically, the increase is very marked among women of childbearing age and has resulted (even more tragically) in an increase in congenital syphilis among children less than one year of age. The frequency of congenital syphilis in 1987 increased 21% over the previous year and another 70% in 1988. Most of the increases were found in poor, urban areas of Florida, California and New York (MMWR 37:486, 1988). How does the Administration propose to control AIDS and HIV infections if it fails to provide sufficient funds to control other sexually-transmitted diseases, such as syphilis, in our high-density urban areas? To cope with this national scourge, the Administration has requested an increase of only $272,000 over the FY 1989 appropriations. The ASM believes this request is inadequate to cope with a problem of such national import. It should be noted that the increase of $272,000 just covers the normal increases in pay raises and fringe benefits and is not enough to prevent the lost of 2 FTEs. Under these circumstances it is apparent that the CDC would have problems mounting an effective national program against sexually-transmitted diseases. Therefore, we urge that the Congress increase the budget request for sexually-transmitted diseases by at least $50 million. Further, we urge not only that the appropriation be increased over the Administration's request, but that significant funding be directed toward state and local programs, which are more capable of reaching at-risk populations.

Immunization of young children has been considered by many one of the most successful activities of the CDC in ensuring quality of life of infants and children. It also is probably the most cost-effective method of preventing human disease and reducing health costs. We are concerned that there is no increase in the requested for project grants over the FY 1989 budget. Therefore, we recommend for FY 1990 an additional $1,114,000 million to maintain the same level of coverage as in previous years. This will buy the same number of doses as in 1979 and provide the same support to states. Over the past few years there has been several major outbreaks of measles in the nation's colleges and universities. The Society believes that it is necessary to investigate the immunization status of the college-age population to prevent reoccurrence of these major outbreaks. The ASM recommends that an additional $20,000,000 be appropriated to carry out the advisory Committee for Immunization Practice's (ACIP) recommendations for measles immunization.

We are very concerned that the Administration has not requested funds to increase the vaccine stockpile in 1990. The contention in the Administration budget that anticipated decreases in vaccine prices due to the Vaccine Compensation Act reducing the cost of vaccine for the stockpile is unfounded. We believe that the stock pile of all vaccines should be raised to a 26 week supply and should include the Hib vaccine. We urge Congress to review this matter in great detail and to consider the reinstitution of funds for the vaccine stockpile, approximately $47 million more to reach the expected level.

As many members of the ASM are practicing clinical microbiologists and physicians in the area of infectious diseases, we are concerned that due to inadequate funding our

National Center for Infectious Diseases can not remain in the forefront of developing studies and strategies for the control of emerging and re-emerging infectious diseases. We are also concerned that the US while exerting great efforts to reduce the cost of hospitalization has not been able to reduce the incidence of nosocomial infections in US Hospitals. If we consider that one-third of all nosocomial infections (about two million per year) can be prevented by appropriate control mechanisms, it is extremely important that community hospitals as well as extended-care facilities are able to call on CDC experts for advice and support. These experts must have the capability to do research in areas of nosocomial infections, associated causes, strategies of prevention, and biology of the microorganisms. Furthermore, the Center must support the education and training of infection control personnel and help develop standards of practice.

Another problem is the continued difficulty in controlling Hepatitis B viruses in high-risk populations. Despite the availability of effective vaccines and antisera, there is still a very high incidence of infection with associated loss of productivity and chronic disease. Of special concern is the disproportionate incidence in our minority populations.

Tuberculosis, a reemerging disease, disproportionately affects minorities, including recently arrived refugees from Third-World Countries, as well as elderly and socio-economically disadvantaged members of our population. Indeed, our indicators show that the tuberculosis problem is worsening and is not controlled by our present public health efforts. In order to support the challenge to eliminate tuberculosis from the US by the year 2010, Congress must support innovative programs. The CDC, in cooperating with state and local authorities, is the obvious leader for administrating such a program. It must also help to develope programs for identifying high-risk groups.

Lyme disease, a newly recognized infectious disease of worldwide significance, requires additional research and evaluation of preventive control measures as well as laboratory diagnosis. Other infectious diseases which should be studied by the Centers for Disease Control are non A/ non B hepatitis, adult T-cell leukemia-lymphoma caused by HTLV 1, causes of fetal death, infections in neonates and the increasing problems of infectious disease transmission in day care centers.

Food borne diseases caused by such organisms as salmonella, campylobacter, listeria, and pathogenic Escherichia coli affect at least six million persons annually, and the number of cases continues to rise. Experts from the CDC must be able to coordinate efforts to prevent such problems which have a major impact on the economy of the United States.

With the increase in the number of elderly persons in the US, we also see an increase of complications due to infectious diseases, both within the healthcare setting and in the home. One problem is the annual occurrence of epidemics of influenza, resulting in up to 50,000 deaths, 200,000 additional hospitalizations, and increased health care costs of nearly ten billion dollars every year. Although influenza vaccines have been available for years, their efficacy has not always been optimal. Research is needed to improve and expand vaccination programs.

With the advent of DRGs and prepaid programs by other insurance carriers, many patients are discharged early from hospitals. This, and the increasing use of outpatient treatment for infectious diseases, has brought highly resistant microorganisms into the community. In previous years such organisms were limited to hospital settings, but we now see increasing numbers of infections with such resistant organisms in community acquired infections. Strategies for preventing and controlling the emergence of such antibiotic resistant microorganisms need to be developed by the scientists of the CDC.

All these programs cannot be supported with the very modest budget requested by the Administration for Infectious Diseases. We strongly urge Congress to consider at least doubling the requested budget for these important programs.

We believe that the US cannot retain its leadership role in international health without well trained experts and scientists in our government agencies. Although insufficient funding affects the entire Public Health Service, we are specifically concerned about its effects on the technical, clinical, and epidemiologic expertise of the CDC staff. We urge the members of Congress to review current government personnel policies before we loose more internationally known experts to non-government and financially more attractive employment. The CDC has brought high prestige to our country and has been a major contributor to the resolution of infectious disease problems worldwide. We hope Congress will continue to support our colleagues in federal employment in order to maintain a high quality scientific and professional staff.

Last year Congress mandated that the CDC conduct five studies to determine the effectiveness of current government regulation of laboratories. The results are to be reported to Congress by May 1, 1990. Funding for these important studies, however, has not yet been appropriated. In order for CDC to identify the quality assurance problems in clinical laboratory testing, it is imperative that money be allocated so that at least some of these studies may begin this year.

STATEMENT OF FAYE WATTLETON, PRESIDENT OF PLANNED PARENTHOOD FEDERATION OF AMERICA (PPFA)

INTRODUCTION

I am Faye Wattleton, President of Planned Parenthood Federation of America (PPFA). I am submitting this statement on behalf of the more than 30,000 volunteers and staff who run our 176 affiliates in 46 states and the District of Columbia, the 250,000 individuals who contribute to our organizations, and above all, the more than 4 million women and men who are served by our clinics each year. I want to thank you and this subcommittee for the opportunity to present our views on the need to strengthen the national family planning program and to expand research in contraceptive technology.

As you know, Title X of the Public Health Service Act is the core of our national family planning clinic network that provides subsidized services to low-income women and teenagers. Title X remains the only program through which Congress can affect and monitor the reach of family planning services; it provides half of all federal funds for basic services; it serves as the base from which other sources of support -- state and local -- can be derived. From its earliest days, Title X has enjoyed bipartisan support in both houses from members of Congress who embrace the concept of voluntary family planning as a tool to enhance the health and welfare of mothers and children -- and to reduce the need for abortion -- through the prevention of unintended pregnancy.

We urge the Congress and this committee to continue its important investment in the Title X program -- one federal program where a relatively small increase in spending this year results in tremendous savings in health care and social services costs to the government for many years to come. The important link between family planning and infant mortality was noted by the National Academy of Sciences' Institute of Medicine in 1985 which reported on the twin problems of low birthweight and infant mortality in the United States, and specifically found that access by low-income women and teenagers to Title X family planning services can significantly reduce incidence of these devastating events.

Specifically, we urge you to support the funding levels contained in S.110, the pending Title X reauthorization bill, which would set funding for basic family planning services at $163 million for fiscal year 1990, an increase over last year's appropriation, but one which would merely bring the program up to its approximate funding level for fiscal year 1981. It is vital that Title X be funded at the full authorized amount and that continuing efforts be made to bring Title X to funding levels that will ensure the continuation of services now being provided -- and to make progress towards expanding services to the millions of women and teenagers in need who are presently not being served. Clearly, federal investment in less expensive preventive services now will avoid the need for larger outlays for more costly services later.

In addition, we request your support for funding at $10 million each two new program initiatives proposed in the Title X reauthorization bill, S.110, which are designed to buttress and improve the provision of basic contraceptive care: the special initiative on contraceptive research and development and the proposed expansion of the information and education section of the Title X statute to encourage the development of community-based educational programs aimed primarily at teenagers and parents.

FAMILY PLANNING SERVICES

Mr. Chairman, the Title X program prevents unintended pregnancies, reduces the need for abortion, and provides basic health services to a large group of medically underserved women. Moreover, in addition to providing basic contraceptive services (including natural family planning) and infertility diagnosis, Title X-supported clinics also offer health screening assessments and either simple treatments or referral for anemia, hypertension, cervical and breast cancer, sexually transmitted diseases, kidney dysfunction and diabetes. Even the Reagan administration called family planning "a vital health care program for women in this country." Clinics such as those financed through Title X often are the first place low-income women - and especially teenagers - receive formal medical care. In addition, U.S. Surgeon General C. Everett Koop and other public health officials have recommended that family planning clinics help provide AIDS testing and counseling services, over and above their existing services. It is obvious that additional funds for this purpose are needed and should be directed to the existing network of family planning clinics around the country now that they are being called upon to assist in halting the deadly AIDS epidemic.

Yet, despite the accomplishments of the Title X program, a tremendous number of women continue to go unserved. In the United States today, there are approximately 31.8 million low-income women at risk of unintended pregnancy (that is, sexually active, fertile and not seeking to become pregnant). In 1983, the last year for which data are available, the organized clinic system made family planning services available to 5 million women, 1.6

million of whom were teenagers and 80 percent of whom were low-income, i.e., below 150 percent of the poverty line. Title X continues to be a major source of funds for this network, comprising 34 percent of the total federal and state expenditures. Primarily through the help of Medicaid or other arrangements, an additional 3.2 million women were able to obtain contraceptive services from private physicians. The rest did not receive services.

In addition, we see a serious, continuing deficiency at DHHS in collecting and analyzing national program data. None of this information has been collected or analyzed since 1983, despite repeated promises by the Department to do so. Thus, while we know, for example, that 31.8 million women nationwide are at risk of unintended pregnancy, we have no up-to-date information on how many of these women are being served in federally-funded family planning clinics, or even how many clinics are in operation. During a time of careful attention to government spending, it is critical to have this information both for congressional oversight and in order for DHHS to allocate funds where they will be most efficiently spent.

Unfortunately, the growing need for the contraceptive and basic reproductive health services provided by Title X has been met by a shrinking federal commitment of funds. In FY 1981, Title X was funded at $162 million. The effects of the 25 percent cut later that year and in FY 1982 were severe. Straining to avoid turning patients away, clinics around the country were forced to reduce the scope of their services, especially community outreach to "hard to serve" patients. They have found it difficult to maintain, much less expand, educational programs geared toward adolescents and their parents -- exactly the sorts of programs Congress wants from Title X. A $16 million increase in FY 1984 and an additional $2.5 million for FY 1985 brought Title X funding from $124 million in FY 1982 to $142.5 million in FY 1985. Funding remained frozen at that level for the next two years. Last year, the transfer of administrative expenses from a general PHS account to the Title X account resulted in a $6 million dollar cut in services. In fiscal year 1989, only $135.1 million is available for family planning services under Title X.

Individual and societal health, and the social and economic consequences of unintended pregnancy and childbirth, however, have not been sensitive to

Congressional budgetary exigencies. Accordingly, individual family planning clinics, hospital programs and others will be searching, often in vain, for ways of adequately serving their patient population's needs.

Looking beyond the statistics and the proven record of accomplishment of Title X-supported programs, I believe the time has come to question the motives and the illogical proposals of those who, explicitly or not, seek to destroy the current national family planning effort. These attacks, and calls to curtail or eliminate the delivery of family planning services, come almost exclusively from organizations whose primary stated mission is to criminalize abortion. Is it possible that they don't realize that eliminating the Title X program would lead to an increase in abortions? That deterring teenagers from seeking contraceptives by imposing parental consent or notification requirements would lead to still more pregnancies among teenagers and more abortions? That excluding medically responsible individuals and organizations from the Title X program or from contracting for delivery of family planning services at home or overseas will lead only to more abortions?

We commend the members of this committee for having resisted riders that would have prohibited family planning clinic personnel from giving their patients confronting an unintended pregnancy full information about their legal medical options. Nevertheless, contrary to congressional intent, the Reagan administration issued regulations barring Title X-funded clinics from providing any women who so request with information, counseling, or referrals regarding their options when facing an unintended pregnancy. These regulations, were opposed in comments filed by 36 state governments, 78 national organizations (including every major medical association) and the deans of all 25 schools of public health in the country, and have been enjoined by two federal district courts. These cases, plus a third, are now before appellate courts.

While divisions on the question of abortion may persist, I submit to you that we must all work together in supporting the means to reduce the need for abortion. Title X is the most tangible vehicle the federal government has for approaching that goal for low-income women and teenagers.

INFORMATION AND EDUCATION INITIATIVE

Due to the consistent reductions in funding for Title X over the past eight years, numerous projects have been discontinued by many agencies, including male involvement and community education and outreach, among others. In order to preserve the core of the program -- the provision of basic contraceptive services to as many individuals as possible -- clinics have had to diminish their information and education activities. These activities are not frills, however, and their discontinuation has had detrimental implications not only for teenagers, but for adult women in light of the extent of public misinformation that exists about current contraceptive methods. It will certainly guarantee a continuation of the high level of unintended pregnancies in this country.

The first of two special initiatives contained in S.110 attempts to redress this situation. It would reauthorize the information and education component of Title X, placing expanded emphasis on the development of community-based programs, targeted and tailored to each community's own needs and designed primarily to reach out to young people and their parents, to help them communicate with each other, and to help them make responsible choices concerning sexuality, pregnancy, and parenthood -- including whether to be sexually active at all at a particular time and, if sexually active, how to choose, among the available methods of contraception, that which is most appropriate at any given stage in their lives. We strongly endorse this initiative, and ask that you provide a separate supplementary fund of $10 million for it to partly alleviate some of the other cutbacks made to education and outreach efforts.

RESEARCH INITIATIVE

The inadequacy of available contraceptive methods is reflected in the fact that more than half of the approximately six million pregnancies that occur each year in the United States are unintended. Moreover, women in the United States are limited in their contraceptive options compared to women and couples in other countries. The new initiative contained in S.110 is designed to overcome present barriers and encourage research into safer and more effective contraceptives.

Title X currently authorizes biomedical research in the reproductive sciences, social and behavioral studies, contraceptive development and contraceptive evaluation. The National Institute of Child Health and Human Development (NICHD) administers all these areas of research, which together are presently funded at approximately $128 million (only a tiny fraction of the total NIH budget) and with only $9 million specifically targeted to contraceptive development. Similarly, much of what we know today about the tremendous health, social and economic costs of adolescent pregnancy - to the adolescents and their families as well as society as a whole - has been generated by work in the social and behavioral research component. It is extremely important that greater financial support be given to all research in human reproduction and population.

We are especially concerned, however, about contraceptive research, with less than 10 percent of the current funding spent on population research going for applied research toward the development of new contraceptive methods and toward evaluating the safety and effectiveness of existing methods.

We understand that the Food and Drug Administration has before it a unanimous recommendation from its Fertility and Maternal Health Drugs Advisory Committee and may soon give its formal approval for the use of Norplant -- a subdermal contraceptive implant -- for use in this country. Yet there are nearly 100 new varieties of contraceptives at various points in the R&D process around the world, including several at NICHD. Some companies even have products ready for field trials, but cannot obtain the insurance so that testing may proceed. With half of the pregnancies in this country unintended, the narrowing of effective choices of contraception constitutes a national tragedy.

There will probably never be a single perfect contraceptive, since individual circumstances change over a lifetime, as do family planning goals and attitudes. Yet in spite of the universal interest in better contraception, federal support for development of new or improved methods, as well as for the evaluation of the safety and effectiveness of current ones, has actually declined since FY 1981. Studies performed by the Alan Guttmacher Institute have revealed a range of obstacles currently facing contraceptive research, development and marketing in this country. These obstacles may be daunting, but hopefully they are not insurmountable. Prominent among them are insufficient and unstable funding, which has declined worldwide by about 25 percent in real dollars since the mid-1970s; the high cost of liability insurance for contraceptive products, which together with the virtual impossiblity of obtaining insurance for clinical tests on humans, is leading to a near-paralysis of research into new methods; and the complex premarketing requirements and regulatory procedures of the FDA which delay approval of many methods for use in the United States. Not surprisingly, only one private pharmaceutical company in this country remains in the business of conducting contraceptive research and development directed towards the United States market.

Mr. Chairman, we need new methods of contraception. And we need to reassure ourselves about the safety and efficacy of current ones. We applaud NICHD's efforts in this area. At the same time, we note that as long as seven years ago, the Office of Technology Assessment (OTA) recommended that an additional $20 million annually be provided in federal funding for contraceptive technology, stating that available research opportunities are only waiting to be exploited. This is not a field for which a single, even a massive, injection of funds would be adequate. Rather, steady and reliable funding at a modestly higher amount could bring some of these leads to fruition.

For this reason, we strongly endorse a specific increase of $10 million for applied research in contraceptive development under the second new initiative contained in S.110, providing for expanded research and development efforts over and above those already being undertaken under the auspices of NICHD.

SUMMARY AND RECOMMENDATIONS

In conclusion, Mr. Chairman, Planned Parenthood respectfully makes the following three recommendations to the subcommittee. First, that funding for Title X be slated at $163 million for fiscal year 1990, adequate to insure a continuation of the vital services now provided, as well as an expansion of services to the millions of women and teenagers in need of services who currently are not being served.

In addition, we recommend that a supplementary fund of $10 million be allocated to allow for the establishment of community-based information and education programs to facilitate and increase communication about family planning services, particularly among adolescents and their parents.

And finally, we recommend that a special supplementary fund of $10 million be provided specifically to boost contraceptive development at NICHD.

In this year of focusing on cost-effective programs, we believe that continued support for Title X and for contraceptive information and research should be high priorities.

Thank you.

LETTER FROM HARRY TETER, JR., ATLANTIC EMERGENCY MEDICAL SERVICES COUNCIL

May 11, 1989

The Honorable Tom Harkin
Labor, Health and Human Services
Appropriations Subcommittee
SD-186 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

The Atlantic EMS Council is an organization comprised of EMS directors of the states of New Jersey, Pennsylvania, Delaware, Maryland, Virginia, West Virginia and the District of Columbia. On behalf of the Council I would like to request that this Committee appropriate the full authorization for the Preventive Health and Health Services Block Grant and $50,000,000 for the Center for Injury Control at Centers for Disease Control. These dollars go to develop and maintain EMS systems in this country; systems which are critical to combatting one of this nation's greatest health problems, trauma. In addition, funding through the Center for Injury Control supports intramural research and technical assistance, extramural research projects, injury prevention research centers, and state and local health agency prevention and control projects.

Trauma is an injury, blunt or penetrating, which is life threatening to the victim. Without proper treatment, victims can die or suffer permanent handicaps. With proper treatment, victims can recover and return to productive normal lives. Proper treatment means having an Emergency Medical Services system in place where an accident occurs. These services begin at the scene of an accident with the timely arrival of an ambulance with a trained rescue crew, capable of instantly rendering life-saving services. By means of an EMS communication system, the crew at the scene can receive medical instructions regarding treatment and directions as to where to transport the patient. Monitoring of this patient begins immediately and critical vital signs are transmitted to the receiving medical facility. The command center will decide the best medical facility to treat the patient, be it the nearest hospital or the nearest trauma center. Finally, in a good system the patient will receive proper rehabilitation and be able to return to a productive life.

Over 100,000 die and 2,000,000 receive life-threatening injuries yearly. Many of these can be averted with proper EMS systems. Unfortunately, these systems do not blanket the country. In many areas there are partial systems and in some areas, no systems at all. As a consequence, many people unnecessarily die or receive permanent handicaps.

The challenge facing all of us in this business is first to prevent the injuries and deaths from ever occurring. Second, recognizing that the most comprehensive prevention program will still not totally eradicate traumatic injuries, we must have proper systems in place providing proper care.

The Atlantic Council wishes to thank you, Mr. Chairman, and the members of the Committee for your support of Emergency Medical Services by providing funds for these systems through the block grant. However, we are concerned that with the recent addition of four former categorical grant programs to the block grant, EMS will fare poorly in competing for precious few funds. Accordingly we request that committee report language mandate that block grant funding levels for EMS be maintained at a level no less than the FY 1989 level.

We are also appreciative of the efforts to establish the Center for Injury Control. It is our hope that this Committee will recommend an appropriations of $50 million for fiscal year 1990. Four years ago the National Science Foundation published Injury In America. This excellent study examined the disease of trauma, its cost and what must be done to combat it. The Center for Injury Control was created at the Centers for Disease Control to do the job. The report listed many tasks to be undertaken. We suggest that given the toll trauma takes on the people of this country, these dollars are not only justified, they are mandatory. We urge your attention to this program and we implore your support.

It is imperative that trauma be attacked by government on all levels; federal, state and local. The Atlantic Council members have been working together for fifteen years to foster complete EMS delivery in our 7 states regardless of state boundaries. We believe in an interstate capability to deliver continuous care when needed. Should an accident occur in one of our states and the proper care facility be in a neighboring state, care can be rendered in both states with no interference. However, we still have needs to address and HHS funds are much needed. Equipment needs to be replaced, manpower must be trained and retrained.

I am pleased to report that the Council has begun a 2-year project to develop a multi-state regional trauma registry. It is the first of its kind and we will be able to look closely at the interstate operations of our system. We will see the magnitude of our trauma which crosses state borders, the kinds of trauma and how our systems are serving trauma victims in the region.

In conclusion, Mr. Chairman, we will never entirely rid ourselves of this dreadful disease. As long as we are content to believe trauma will never strike us, we will continue to be blinded to the cure. As long as intoxicated persons drive, as long as seat belts go unused, as long as we ignore the great advantages of air bags, we will have trauma of epidemic proportions. Behavior patterns seem almost impossible to change. Even if we were to mandate these preventive programs, trauma would still not be totally eliminated. And as long as trauma continues we will need EMS systems. The goal of a blanket of interlocking systems nationwide must be pursued. No matter where we may find ourselves, an EMS system should be there to protect us. We will continue to need the tools to build our systems. The Preventive Health Block dollars cannot begin to address all the EMS needs, but they help.

In addition, CIC needs to continue research into how we can more effectively deliver this care. The Atlantic Council welcomes the opportunity to work with CIC to effect better EMS research. The Atlantic Council members look forward to working with you in any way possible to advance this service both regionally and nationally.

Thank you for the opportunity to present our testimony for the record.

Sincerely,

Harry Teter

Harry Teter, Jr.
Executive Director

STATEMENT OF NANCY DALY, PROJECT CHANGE

[illegible] P.L. 96-272 (The Adoptions Assistanc [illegible] Child Welfare Act of 1980) was enacted by an overwhelming bipartisan Congress, Congress planned to increase funds under Title IVB (child welfare services) to stimulate more preventive services to families to keep them intact and to prevent unnecessary removal of children into foster care. At this time, all of the many professionals working in children and family services believed that there would now be an opportunity to preserve families and break the cycle of children being removed from their families and lingering in the foster care system until they turned 18, whereupon they are released from the system with no training, no home and no hope.

Unfortunately, the FEderal funding for the Child Welfare Services Program, authorized under Title IVB of the Social Security Act, has increased only gradually, still failing to reach its full authorization level eight years after passage of the law.

Currently, with families disintegrating all around us, we see more and more youngsters committing senseless murders and other serious crimes. These are children who are described as "children without conscience," and it is critical that we waste no time in exploring ways in which to strengthen families. Children who grow up in foster care have no sense of their own history, no one who has saved their drawings, or schoolwork, and no one who remembers when they first walked, or talked or cried.

The way the system is currently funded, there is no incentive to [illegible] keep families together. The in[illegible] keep [illegible] ster care which is an entitlement pro[illegible] am [illegible] hat these funds be capped, because t[illegible] of children being placed in foster care has steadily in[illegible] due to many factors, including the increase in alcoholism and drug abuse, the increase in single-parent homes, children living in poverty, and an increase in the awareness of child abuse within the community. However, given the severe strain being placed on the child welfare system, in many areas, protective services are limited to cursory investigations and only sporadic monitoring of troubled families.

There are fewer qualified foster families available because most families cannot afford to be foster parents, and because training is not mandated, many of the available foster parents are not prepared to deal with the severely troubled children who are entering the foster care system, These youngsters are moved from placement to placement, with each move resulting in the child suffering more psychological damage.

Children who are maltreated are especially at risk for being denied the opportunity to develop normally. Their lives are often filled with misery and the maltreatment conditions make it difficult for them to enjoy or fully participate in positive life circumstances. This leads to their being unable to participate fully as contributing members of society as adults. Rather, maltreated young children often grow up to be teen-age suicides, criminals, school failures, mentally ill and homeless. In fact, 57% of antisocial and deviant personalities have a child abuse history; 97% of criminals incar- [illegible] crimes have a child abuse histor[illegible] have a child abuse history; 90% [illegible] have a child abuse history; 75% of domestic violence cases have a child abuse history; and 36% of runaways have a child abuse [illegible]

[illegible] til a significant investment is made in [illegible] e approach to families at risk, the coun[illegible]

[illegible] ed alive" by massive caseloads w [illegible] sight. The Federal Government must provide the incentive for citizens and professionals to take the initiative to provide alternative programs to preserve families. Programs that provide preventive services must be developed and expanded. I would propose the development of model neighborhood family support systems which would link together public and private sector resources in a partnership to better address the needs of families at risk of abuse or neglect. There are many programs across the country that provide services to families, and these programs must be encouraged and supported, but in addition, it is important to create a mechanism that could co-ordinate these services and provide a continuum of services to families in a community.

There is no doubt that children are best cared for in the context of their own families. The most effective child advocacy, then, is family advocacy. Mutual trust must be developed between the family in need and the agency providing the services, preferably without the onus of court intervention. The neighborhood family center could assess the troubled family's strengths, weaknesses [illegible] needs. The assessment should examine the total family system [illegible] with the surrounding environment. [illegible] plan be developed to address their [illegible] family support system would mobilize the community resources [illegible] help multi-problem families meet their basic needs. The staff of the program would serve as the catalyst to combne new and existing programs into a coherent, accessible neighborhood social service system. The system would identify three levels of [illegible] ng with levels of family need.

[illegible] encompasses the basic needs of

-- physical needs which include transitional housing; prenatal and basic preventive health care; adequate nutrition via food banks, gleaning and co-ops; and economic opportunity [illegible] to job training and placement

-- child care which includes parenting education; information and referral; counseling; network of Family Day Care providers
-- family advocacy which includes an ombudsperson to serve as local intermediary with government agencies serving families, education for self advocacy

Early Intervention--includes community referral network; family advocates and family support programs

Protective Services--working with families identified as abusive or neglectful to prevent out-of-home placement, including family assessment; in-home supportive services such as respite care, demonstrating homemakers, and intensive help from a family advocate team; and family treatment, family mediation services and out-of-home placement within the community where the child could stay while family [illegible] could begin.

[illegible]s system is to mobilize community help families to meet their basic needs. Many of the service elements proposed already exist in varying degrees throughout communities. But, they are not equally distributed, nor does any one neighborhood already have in place the type of coordinated system I have described. What is required, then, is not only agreement with a new philosophy of family support, but the development of a neighborhood-based system to put those principles into action.

In order to support the type of programs described above for the preservation of families, Title IVB of the Social Security Act must be fully funded. In 1980, Congress authorized a cap of $266 million, but never funded to that amount. Title IVB must be funded well in excess of this amount in order to adequately fund family preservation services nationwide. In addition, any new dollars going to states should be earmarked for prevention/ early intervention services, with a focus on short-term demonstration projects with outcome measures.

[illegible] opportunity to present my testimony [illegible] Committee, and I hope that you will support the preservation of th[illegible] the number one priority for our Country in the c[illegible]

STATEMENT OF HELLA K. FRANK, R.N., PRESIDENT, FEDERAL PROFESSIONAL NURSES ASSOCIATION

I am Hella Frank. I represent the full-time Federal occupational health nurses who staff the government's Public Health Units. We nurses appreciate this opportunity to submit testimony to your Committee regarding the delivery of health care to Federal employees. The critical health issues which we called to your attention four years ago remain unresolved. The health care provided to Federal employees by the Public Health Service continues to deteriorate and the job security of the full-time Federal nurses who staff the PHS Units remains in jeopardy.

After we nurses submitted testimony last year, this Committee adopted Report language in which you repeated your conviction that it is in the best interest of Federal employees for the Public Health Service to continue to operate health units throughout the Government under reimbursable agreements and to staff those health units with full-time Federal occupational health professional positions. You once again voiced your disapproval of the Department's determination to staff these units with contract positions. This Committee then directed the Department to submit an annual report detailing the status of the FEOH Program, the utilization of full-time Federal occupational health professional positions to staff the health units and the procedures adopted to protect the rights of the career employees who staff these units.

Another year has passed. I am sorry to report again that both the quality of Federal employee health care and our job security remain under threat.

Over the past years, despite the concern of this Committee, the level of full-time Federal occupational health employees nationwide has declined drastically. Contemporaneous with the steady loss of skilled occupational health nurses from PHS, the Department last January released the Final Report of the Secretary's Commission on Nursing.

This expert panel concluded that a widespread shortage of RNs exists; that the shortage is critical and that it is adversely affecting the quality of patient care. Among the urgent proposals to alleviate the critical shortage of nurses, the Commission recommends that immediate action be taken to improve both nurse compensation and the nursing working environment so as to discourage RNs from abandoning their nursing careers.

Yet the Department, in an almost schizophrenic response, has committed itself to a policy of privatization which has already caused a serious loss of qualified nursing personnel as well as a steady decline in the quality of health care provided to Federal employees.

The Department's action, we believe, is inconsistent with the urgent recommendations of the Commission and places the health of government workers at risk. While the demand for the specialized services of occupational health nurses continues to grow, the Department insists on replacing full-time Federal nurses with contract nurses. We think this short-sighted strategy is the cause of the problem. The use of contract nurses to staff Public Health Units is the reason for the deterioration in the quality of health care government workers receive in the workplace.

Most contract nurses lack the essential skills of the occupational health nurse. These skills -- according to the American Association of Occupational Health Nurses -- are derived from several disciplines in the health sciences including nursing, medicine, safety, industrial hygiene, toxicology, administration and public health epidemiology.

Furthermore, most contract nurses are temporary employees. They do not stay long at any one agency. They do not get to know the employees and their environment. Consequently, there is no continuity in patient care. Contract nurses receive little or no supervision or evaluation. They develop no institutional loyalty. They do not care about the future of the occupational health program. And to top it all, they cost the government more than we do. The most recent Department statistics we have been able to obtain demonstrate clearly that there is no cost efficiency gained by hiring contract nurses to replace us.

In fact, the Administration's effort to privatize the delivery of health care to Federal employees by replacing Federal full-time occupational health nurses with inexperienced, transient contract nurses continues to be a costly failure. Supply side economics has no place in our health units. The privatization of our specialized occupational health services is directly responsible for the measurable decline in the quality of health care government workers now receive on the job. In our view privatization is an abdication of responsibility by the Department rather than a commitment to better care for Federal employees.

Privatization simply has not worked in the Public Health Service. The scarcity of qualified contract nurses has created a serious personnel crisis. Public Health Units throughout this Region, including those in the Washington, D. C. area, frequently are understaffed. Relief nurses are hard to find. Full-time nurses are over-extended.

Furthermore, the Department has yet to institute a screening process to insure that contract nurses are qualified in occupational health nursing. As a consequence, when contract nurses are assigned to Public Health Units, the number of clients served declines. Federal workers do not use Public Health Units as frequently when contract nurses are on duty. As a result, employee productivity declines. We think that a loss of confidence has ensued. Government workers recognize the poor quality of health care privatizing provides. Within the past year, numerous Federal agencies as well have protested the dramatic increase in the cost of privatization.

Those in PHS responsible for the management of the Federal Employee Occupational Health Program continue to be concerned over agency dissatisfaction with contract nurses. We think that privatization is causing permanent damage to FEOH's reputation and credibility. PHS management is aware of the damage and now concludes that it is essential to assign at least one full-time Federal professional occupational health nurse to each unit. The Department believes that this assignment is necessary in order for PHS to establish proper liaison with agency management and for PHS to provide on-site occupational health expertise as well as some supervision over the quality of service provided by contract nurses.

The assignment of one full-time Federal occupational health nurse to each unit is merely a partial answer to the problem created by the use of contract nurses. To restore the quality of health care Federal employees deserve, PHS units must be staffed solely with full-time Federal professional occupational health nurses.

We urge this Committee to remain critical of PHS's risky policy of privatization and consultation. We urge you to continue your oversight of the Federal Employee Occupational Health Program. We ask that you include language once again in your Report directing the Department to preserve the quality of health care available to Federal employees in the workplace and to protect the job security of the full-time Federal nurses who staff the PHS Units.

Also, we request that you direct the Department again to provide an annual report on the extent and cost of using contract services to operate PHS Units.

Finally, Mr. Chairman, we nurses want you to know how deeply we appreciate your Committee's efforts to preserve the quality of health care for Federal employees and we are thankful as well for the concern you have shown for our welfare.

STATEMENT OF WILLIAM J. LUCCA, JR., EXECUTIVE DIRECTOR, COMMISSIONED OFFICERS ASSOCIATION

Mr. Chairman and Members of the Committee, the Commissioned Officers Association (COA) appreciates the opportunity to present its views and recommendations on several provisions in the Department of Health and Human Services' (DHHS) FY 1990 Budget that, if approved by the Congress, will adversely impact continued use of Commissioned Corps personnel in fulfilling the nation's health mission.

We request that the Administration's provision be weighed against the positive results achieved by former Secretary Bowen's proposal for REVITALIZATION OF THE COMMISSIONED CORPS which was implemented in FY 1988. The major purpose of that proposal is to delineate specific management activities to be undertaken to improve the effectiveness, efficiency and productivity of the Commissioned Corps.

Several provisions in the DHHS budget are of concern to the COA. It is our belief that they are designed to systematically erode the strength and vitality of the Corps to the point where its effectiveness will be seriously diminished. At the very least, they will undermine the good results already apparent from Secretary Bowen's revitalization process. Candidly, the

COA was astonished that the Administration, at the bidding of the Office of Management and Budget (OMB), persists in sending these worn-out and unacceptable provisions to the Congress. The COA urges the Committee to reject them as you have done in the past.

An indentification of the OMB proposals in the FY 1990 BUDGET APPENDIX, together with discussions and recommendations, follows:

I-K28 Retirement Pay and Medical Benefits for Commissioned Officers.

For retirement pay and medical benefits for Commissioned Officers, OMB has eliminated the "such sums as may be required during the current fiscal year", and proposes instead for FY 1990 the sum not to exceed $105,201,000 and an additional $5,000,000, if necessary.

The retirement and medical benefits appropriations approved by Congress for the Public Health Service has, for many years, been an open-ended and indefinite appropriation specifiying "such sums as may be required". This method, together with reasonably accurate annual projections and careful management of the rise of the entitlement, has proved to be satisfactory.

It should be noted that the Congress, in its wisdom, rejected a similar provision in FY 1989.

Recommendation: That the Committee reject OMB's proposal and restore the language which would specify "such sums as may be required".

I-K47 GENERAL PROVISIONS

Sec. 208 Ceiling on Salaries

This provision would impose an absolute ceiling of $120,000 annually for salaries and related benefits for Commissioned Corps Officers.

This is a discriminatory pay provision that would inhibit managerial ability to freely assign competent officers to key posts. Further, such a provision does not exist in the military pay structure and is without justification.

Recommendation: That the Committee reject the proposed provision.

Mr. Chairman, our organization appreciates the thoughtful work of this Committee in providing adequate funding for health programs that are so important to the physical and mental well-being of our nation's citizens. We are hopeful that you will be able to accept our recommendations with respect to the several budget provisions discussed in this statement.

STATEMENT OF THE AMERICAN VETERINARY MEDICAL ASSOCIATION AND THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

We appreciate the opportunity to present the American Veterinary Medical Association (AVMA) and the Association of American Veterinary Medical Colleges (AAVMC) FY 1990 budget recommendations for Health and Human Services and Education. Our associations represent nearly 50,000 veterinarians and all of the veterinary medical teaching and research components of the university system. The veterinary medical colleges and many of the Departments of Veterinary Science play and important part in basic medical research and applied research which contributes directly to human health. Veterinarians protect and promote human health and welfare through control and prevention of zoonotic diseases and protection of the food supply. They are also responsible for the health and welfare of animals used in biomedical research.

We are especially concerned with three funding areas within the National Institutes of Health of the Public Health Service. These are (1) the Research Resources Division, (2) the NIH Health Research Programs and (3) the Health Resources and Services Administration.

RESEARCH RESOURCES DIVISION

The Animal Resources Program in this division contains the NIH programs for Laboratory Animal Sciences and Primate Research. It supports various types of institutional, regional and national resources which are essential for the advancement of research efforts on many important human diseases. These include the Regional/National Primate Research Centers; diagnostic and laboratory services to promote optimal health status of laboratory animal colonies at major medical institutions; development of new mammalian and alternative (non-mammalian) models for biomedical research use; upgrading of institutional animal facilities; breeding and research on special animal colonies (including chimpanzees and specific-pathogen-free rhesus monkeys for use in viral hepatitis and AIDS research); and specialty training of veterinarians in laboratory animal medicine.

In order to conduct these critical programs a substantial funding increase of approximately 20 percent above the President's Budget is urgently needed. This support would allow the Division to more nearly provide the necessary laboratory animal resources and meet the need of the national biomedical research community.

NIH RESEARCH PROGRAMS

We join the 38 members of the Coalition for Health Funding and the more than 150 other organizations represented by the Ad Hoc Group for Medical Research Funding in recommending $8.416 billion for the National Institutes of Health. This will provide only a slight increase above the FY 1990 Current Services estimate of nearly $8 billion.

This level of funding will allow restoration of funding of research project grants to the recommended level and maintain some growth in the system (to 6427 grants) to provide support for new people and new ideas. It would allow full funding of one out of three approved competing research project grant applications in FY 1990.

An adequate number of research trainees is a critical need in the provision of current and future health care. The level of funding recommended will allow an increase of 5 percent over the FY 1988 number of research trainees. It would also support approximately 250 additional research career awards.

We are especially concerned about the potential loss of the Biomedical Research Support and strongly recommend that this important program be continued since It provides essential support for the research infrastructure. The loss of this program would have severe adverse effects on the initial base support of some of the most creative and innovative research activity.

A second area of special concern is the Minority Biomedical Research Support program. Our society simply cannot ignore the core support necessary to increase support of minorities in biomedical research and/or the support of medical problems which have a proportionally adverse impact on the minority communities.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

We recommend $1.882 billion in FY 1990 support for this unit. That amount would provide adequate funding for maintenance and a moderate increase in a wide range of programs which provide core community health services to patients with special needs and educating ethnically and economically diverse health professionals.

Title VII of the Public Health Service Act was reauthorized in the fall of 1988 and we strongly recommend that it be funded at the full authorization level. This is of special concern to all of the health professions because it provides critical support needed to achieve national health care priorities. Specifically it will assure access to health professions training by minority and disadvantaged individuals and health professions training in areas of urgent, national need. Funding would assist health profession training institutions to provide training in underserved areas and encourage health professionals to practice in those areas.

Veterinary edical students, like those in the other health professions, are heavily dependant on Scholarships for Students of Exceptional Financial Need, the Health Education Assistance Loan program and the Health Professions Student Loan program. The veterinary profession has worked very hard to increase the numbers of minority students and finds that the special financial aid packages made available through Title VII programs are absolutely essential. With 86 percent of all veterinary students graduating with an average debt load above $20,000 and with starting salaries just slightly above this figure these students are having a difficult time financing their education. The unmet need for financial aid gets greater each year as the universities increase fees more rapidly than the general cost-price-index. Without these federal financial aid programs many veterinary students would simply be unable to complete their professional education.

SUMMARY

We would like to call attention to the significant benefits derived from human research which may be applied to animals as well as the significant benefits derived from animal research which is applied to humans. All biomedical research conducted for the purpose of improving human health has spin-off applications to improved animal health and efficiency of animal production. Funds provided for research through NIH make indirect contributions to the broad area of animal health and welfare and from that to human health and welfare through an increased level of food safety and a higher standard of living.

STATEMENT OF ROY E. ALBERT, M.D., DIRECTOR, EDUCATIONAL RESOURCE CENTER, UNIVERSITY OF CINCINNATI

Chairman Harkin, Members of the subcommittee, I am Dr. Roy E. Albert of the University of Cincinnati. I am director of the Educational Resource Center at our Institute of Environmental Health and the President of the Association of University Programs in Occupational Health and Safety (AUPOHS).

As you know from our previous testimony about the ERC program over the past eight years, the fourteen regional university-based ERCs operate under training grants of the National Institute for Occupational Safety and Health (NIOSH). The ERC program, launched in 1977, carries out the mandate of the Occupational Safety and Health Act to ensure an adequate supply of trained professionals in the multidisciplinary fields of occupational medicine, industrial hygiene, occupational health nursing, and occupational safety. A research training program at the regional ERCs was subsequently mandated by this subcommittee several years ago; in part to attract graduates into academic teaching and research, an area of significant shortage. A background sheet on the ERC program is attached to my state-ment, listing key areas of research and educational courses being offered, and locations of each of the universities carrying out the program.

In addition to the graduate academic training programs at ERCs, an extensive continuing educa-tion and outreach program is offered. A wide variety of such continuing programs provide ongoing professional refresher courses and specialized training to many thousands of occupational safety and health practitioners in industry, labor, academia, and state and local public health personnel. We estimate that these courses have reached 100,000 people over the last five years. NIOSH also provides training funds for about twenty-five single-discipline project grantees at other academic institutions out of its meager training budget, currently $10,095,000 for Fiscal 1989. This year, the fourteen ERCs will receive a combined total allocation of only $7.2 million for training and about $1.2 million for all the ERCs research ~~training~~ activities. The total funding for all project grantees will amount to only $1.2 million.

Mr. Chairman, we know that the Members of this subcommittee have, over the past eight years, shared our concern over the growing shortages of trained occupational health and safety professionals to deal with the increasingly complex health hazards of Americans in the workplace environment. For six consecutive years, the previous Administration requested ZERO funding for occupational safety and health training programs. This committee and its Senate counterpart for six consecutive years kept the ERC program alive in the face of severe budgetary constraints to maintain a Federal commitment to the health and safety needs of American workers. For this wisdom and continuing support, we are grateful.

But the long span of underfunded training programs has taken its toll. ERCs have vigorously pursued all possible sources of non-Federal funding support. Some ERCs are located at state-supported institutions, but budget cuts in state legislatures over the past eight years have also been the rule. Many of our programs had insufficient time to stabilize the cuts in both Federal, state, industry, and other private support. A majority of ERC faculty members are non-tenured at their institutions and many promising students withdraw from occupational safety and health career choices because of this lack of support and the uncertainty of completion of their training requirements. Meanwhile, the manpower shortages in key occupational health specialties are exacerbated. Shortages of funds at all ERCs has resulted in a continuing decline in the numbers of students receiving graduate training in the four major occupational health and safety disciplines and a corresponding decline in those graduating.

For example, upwards of 90 percent of all of the limited number of occupational medicine practitioners in the United States are the products of the ERC program. But only 122 physicians received full-time training in occupational medicine at ERCs last year and total numbers of such graduates were less than half that figure. The overall impact of Federal budgetary restraints in recent years can be measured by the fact that almost 800 students at ERCs graduated in each of the peak budget support years of 1980-1981, when the Federal appropriations were $12.9 million; the current level of graduates is down by about two-thirds.

Shock waves of the severe cuts contained in the Reagan/Bush budget for Fiscal 1990 for both NIOSH and the ERC training grant program are reverberating in each of our academic institutions. As you are aware, Mr. Chairman, the proposed NIOSH budget would be cut from the Fiscal 1989 level to $70.4 million to $44.6 million -- almost 35 percent! The training budget of NIOSH, including the ERC program, would be slashed even more drastically -- from $10 million to $3.3 million! This is on top of the 42 percent decrease that NIOSH experienced in actual purchasing power during the Reagan Administration years! Such irresponsible budget cuts, in our judgment, represent a total abrogation of the Federal responsibility to the millions of American workers whose health and safety Congress promised to protect in the Occupational Safety and Health Act that created NIOSH. Cuts of this magnitude in both the NIOSH research and training budget lines would be the death knell for any meaningful health and safety research at the intramural or extramural levels and would virtually terminate the ERC program. This program has a proven track record for cost-effectiveness over the years of its existence.

I have attached a table to my testimony that measures the dramatic impact of NIOSH budget cuts during the 1980's in the face of rising costs of research and development. You will note that the Fiscal 1980 appropriation for NIOSH was $80.4 million (base year), of which $12.9 million was for training and the ERC program. In Fiscal 1990, it would require a NIOSH appropriation of $148 million just to equal the comparable funding of 1980! Or to put it another way, the Fiscal 1990 Administration budget request of $44.6 million represents only 30% of the 1980 budget in real dollars ($24.2 million) for NIOSH! If these same real dollar figures were to be applied to the ERC training program, an appropriation of $23.8 million in Fiscal 1990 would be required just to keep the same level of training activity as existed in 1980! Mr. Chairman, we sincerely hope that your subcommittee carefully considers these factors in making your judgment on the level of funding this year for NIOSH and the ERC training grant program.

Occupational health and safety workplace hazards have become increasingly complex. When extremely hazardous situations have been identified, it requires highly skilled and broadly trained and experienced professionals to evaluate the real causes of injuries and illnesses so that effective and low-cost remedies can be developed and put into place. Our present level of occupational health and training activity in the United States is simply not meeting the demand for such professionals. Consider that the annual cost of occupational injuries and illnesses in our country is now estimated by the NIOSH Board of Scientific Counselors to be $200 billion! This amounts to about $1,667 per worker each year! Yet at the current budget level of NIOSH -- $70.4 million -- this amounts to a public investment per worker of only 58 cents! By comparison with other highly industrialized countries, Sweden -- for example -- spends the equivalent of $7.64 in preventive occupational safety and health programs for each of its workers! Even a country like Australia invests $3.66 per worker in its health and safety programs annually. These statistical comparisons become even more startling when we realize that occupational musculoskeletal disorders alone cause the disability of some 12 million workers in the United States each year, while occupational traumatic injuries on the job disable another 10 million workers and result in the death of another 10,000 persons. Occupation-induced hearing loss affects some 500,000 American workers annually. Great numbers of these fatalities and disabling injuries could be prevented by more effective, professionally-directed safety and health programs in the workplace. For example, ERC graduates in ergonomics are concerned, along with other issues, with the prevention of musculoskeletal injuries that are so common in the workplace. The annual compensation cost for low back injuries is some $4 billion, at a per case cost of $6,000. The Federal investment in an ERC graduate averages about $10,000, so that if, during the entire career of a trained ergonomics graduate, he or she prevented only two workers from low back injury, it would more than repay the cost of such investment, plus the lost productivity of such workers and the elimination of pain and suffering they would otherwise incur. Similarly, even a modest reduction in the tax free workers compensation payments by prevention of injury and disease would mean increases in annual Federal tax revenues of tens of millions of dollars. We hear much today about the urgent need for America to become more competitive in manufacturing industries so as to reduce our trade deficit and increase our productivity per worker. I submit, Mr. Chairman, that the prevention of even a modest portion of the staggering losses of man-hours of work, the loss of industrial productivity, and the escalating costs of worker disability and death claims resulting from the ten leading causes of work-related diseases and injuries identified by NIOSH would produce dramatic dividends throughout our economy.

NIOSH BUDGET BASED ON THE RESEARCH AND DEVELOPMENT PRICE INDEX
BASE YEAR -- 1980

	YEAR	ACTUAL DOLLARS	REAL DOLLARS	EQUIVALENT DOLLARS
	1970	$10,353,000	$21,000,000	$ 39,628,326
	1972	26,267,000	47,967,495	44,017,183
	1975	33,999,000	50,331,606	54,298,041
Best Year	1980	80,382,000	80,382,000	80,382,000
	1985	65,337,000	45,840,876	114,568,465
	1986	64,551,000	43,386,880	119,592,340
	1987	70,093,000	44,908,380	125,460,226
	1988	69,668,000	42,235,829	132,590,109
	1989	70,355,000	40,329,607	140,226,399
	1990	44,586,000	24,202,584	148,079,720

We are painfully aware, Mr. Chairman, of the difficult budgetary situation which confronts our Federal government and the major effort that is required to get the deficit under control. But we are also firmly convinced that both the long-term and near-term benefits of an effective occupational health and safety effort are of such vastly significant importance to the Nation to warrant additional funding support this year on the basis of factual information presented here. The great benefits to our economy, to our competitive position in the world, as well as to American working men and women, far outweigh many times over the modest investment in NIOSH research and training programs. We therefore urge that you seriously consider the appropriation for Fiscal 1990 of a total of $85.8 million for NIOSH activities, including $69.3 million in the research line and $16.5 million in training line of the CDC/NIOSH budget; the latter figure includes a modest restoration of lost ground in the ERC and project grant training programs and a small expansion of the research training effort just recently begun.

We thank you for your past support of our work and sincerely hope that your evaluation of the progress we have made in occupational health and safety education despite limited funding will merit your favorable action on our budgetary request.

STATEMENT OF THE NATIONAL REHABILITATION CAUCUS

EXECUTIVE SUMMARY

Today, medical and community-based rehabilitation facilities are finding it increasingly difficult to recruit and retain sufficient numbers of qualified rehabilitation professionals to treat their patients and clients. The most severe shortages are of occupational therapists, physical therapists, speech-language pathologists and audiologists and respiratory therapists.

The 100th Congress recently enacted the "Health Omnibus Programs and Extension Act of 1988", P.L. 100-607, which contains two provisions that would make available in each of FYs 90 and 91 $2 million each for faculty and program strengthening and for traineeships for advanced training of allied health professionals, including rehabilitation therapists. However, these funding levels are grossly inadequate to meet the present rehabilitation needs of the nation's elderly and disabled individuals.

The need for these professionals far exceeds the supply in all but a few places in the country. This shortage will become more severe in the future as the numbers of the elderly increase and advances in technology save and prolong life. In fact, Hospitals recently reported that:

> "The nurse shortage crisis has affected the quality of direct patient care, and its causes and implications have been well documented. But another crisis is imminent: a shortage of allied health workers. And until a solution to the problem is found, a wide range of hospital services will be affected. In fact, a recent study from the Institute of Medicine (IOM), Washington, D.C., projects that by the year 2000, the demand for physical therapists will increase by 87 percent... and occupational therapists, 52 percent." (November 5, 1988).

Something must be done to increase the number of rehabilitation therapists in the workforce. Simply put, existing educational programs for rehabilitation professionals cannot meet the current demands or increase the numbers of graduates to meet these needs. This is due to lack of funding for program development or expansion, inadequate supply of faculty and little or no funds for scholarships or loans to attract students into the programs, including minority students.

Thus, the National Rehabilitation Caucus representing medical and community-based rehabilitation therapists and facilities recommend that the 101st Congress support full funding of the FY 1990 authorization levels approved in P.L. 100-607 for rehabilitation personnel faculty and program development, traineeships for advanced training and a new loan repayment program.

I. INTRODUCTION

Mr. Chairman:

Over the last few years, medical and community-based rehabilitation facilities have been experiencing problems in recruiting and retaining qualified rehabilitation professionals to treat patients and clients. The primary areas of concern are with the numbers of physical therapists and occupational therapists. Facilities have resorted to bonuses, career ladders, flexible schedules and hours, paying child care expenses, continuing education, and other strategies to retain hard won therapists. Two new companies were created over the last two years solely to help recruit qualified therapists from abroad. Yet even these innovative measures have not alleviated the shortages.

The National Easter Seal Society's recently published monograph on "Recruitment and Retention of Rehabilitation Professionals in the Nineties and Beyond," which explores the dimensions of the shortage of rehabilitation professionals, similarly notes that "society faces a diminishing pool of physical and occupational therapists, speech-language pathologists, and nurses", and "such shortages are both significant and growing." Further, a report released in the Fall of 1988 by the Institute of Medicine, a division of the National Academy of Sciences, declared that unless policymakers intervene, the health care industry will suffer from a "serious shortage of allied health professionals". Specifically, the IOM pointed out that the most serious shortage by the year 2000 could occur in the fields of physical and occupational therapy. Finally, at a recent meeting, the Prospective Payment Assessment Commission (ProPAC), revealed results of a 1988 study its staff conducted on personnel shortages in hospitals. ProPAC reported that in addition to the nursing shortage, "there is also a shortage in some allied health areas such as physical therapists (and) occupational therapists."

II. PUBLIC LAW 100-607: MODEST RELIEF AT BEST

The 100th Congress recently enacted the "Health Omnibus Programs and Extension Act of 1988", P.L. 100-607. Title VI of that Act, the Health Professions Reauthorization Act of 1988, originally was introduced as legislation (S. 2229, H.R. 4983) to reauthorize Title VII of the Public Health Service Act. Congress, in its last few days, combined these and other health bills into one extensive omnibus bill. Unfortunately, not all the original language and provisions in S.2229 concerning allied health professionals in general and rehabilitation therapists in particular were adopted.

Specifically, P.L. 100-607 does provide for:

A. $2 million in each of FYs 1990 and 1991 for allied health project grants and contracts--(Section 624). This Section makes available at the discretion of the Secretary of HHS, funds for faculty strengthening. In addition, funds will be provided for "improving and expanding program enrollments in those professions in greatest demand and whose services are most needed by the elderly," and "training programs that promote the effectiveness of allied health practitioners in geriatric assessment and the rehabilitation of the elderly";

B. $2 million for each of FYs 1990 and 1991 for traineeships for advanced training of allied health personnel--(Section 625). This will help faculty shortages by providing some funding to "plan, develop, establish, expand and operate doctoral programs for the advanced specialty training of allied health professionals". The Secretary of HHS must limit these discretionary grants and contracts to those allied health fields that have the most "significant shortages" of practitioners and which have a "significant role in the care and rehabilitation of patients who are elderly or disabled";

C. $2 million in each of FYs 1989-91 for a loan repayment program for allied health personnel--(Section 604).

The Secretary of HHS also must submit a report to Congress in 18 months containing information and analysis of assessments of "health manpower" shortages.

While this law does provide an important first step to help alleviate the shortage of rehabilitation professionals, the funds authorized are insufficient when compared with what is actually required. As well, no funds are authorized by P.L. 100-607 for entry level allied health students' assistance.

III. CONCLUSION

The educational system for the rehabilitation professions has not been able to meet the demand for core rehabilitation therapists. This inability to produce enough therapists is caused by:

- Inability to increase class sizes for lack of funds
- Inadequate number of educators in these professions
- Shortage of programs nationwide in certain professions
- Decreasing funds for scholarships and loans to attract students into these programs.

The National Rehabilitation Caucus urges that the 101st Congress appropriate funds for a substantial grant program to fund the expansion or development of new programs, increase the number of qualified faculty and attract students into these critical rehabilitation fields.

IV. RECOMMENDATIONS

Given the extreme shortages of occupational therapists, physical therapists, speech-language pathologists and audiologists and respiratory therapists, the National Rehabilitation Caucus urges the Appropriations Committee to support full funding of the FY

1990 authorization levels contained in the following sections of Title VI of the Health Omnibus Programs and Extension Act of 1988 (P.L. 100-607):

- Section 604, Loan Repayment Program for Allied Health Personnel, $2 million [Section 751 of Title VII, the Public Health Service Act];
- Section 624, Allied Health Project Grants and Contracts, $2 million [Section 751 of Title VII, the Public Health Service Act];
- Section 625, Traineeships for Advanced Training of Allied Health Personnel, $2 million [Section 797 Title VII, the Public Health Service Act].

The NRC also urges the Appropriations Committee to incorporate in its Committee report language to require the Secretary of HHS to provide grants for and enter into contracts with schools of physical therapy and occupational therapy under Title VI, Sections 624 and 625 of P.L. 100-607.

STATEMENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

The Association of Schools of Public Health (ASPH),* representing the 24 graduate schools of public health in the U.S. and Puerto Rico (see attachment A), urges the committee to approve its request of $21 million in FY90 funds for academic public health programs of the Health Resources and Services Administration (HRSA) and of the Centers for Disease Control (CDC).

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* ASPH is the only national organization representing the Deans, faculty and students of the 24 schools of public health. The schools represent the primary educational system that trains personnel needed to operate our nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

The Institute of Medicine, in its 1988 report on The Future of Public Health, mentioned "the need for well trained public health professionals who can bring to bear on public health problems the appropriate technical expertise, management and political skills, and a firm grounding in the commitment to the public good and social justice that gives public health its coherence as a professional calling." One of the problems in meeting this need is the scarcity of financial resources available to academic public health institutions. Another problem, identified by the U.S. Public Health Service, is the existence of shortages of certain public health professionals.

These two problems may be solved by continued federal support to the schools of public health. As the IOM report said, there are several ways to a career in public health, "but the most direct is to obtain a degree from a school of public health."

The supply and demand of public health professionals cannot be determined as precisely as those for physicians and nurses. Yet, in the last three reports to Congress on the status of health personnel in the U.S., DHHS concluded that shortages of personnel were likely in several public health specialists trained in schools of public health: epidemiologists, environmental health professionals including toxicologists and hazardous waste managers, biostatisticians, nutritionists, public health nurses and physicians trained in public health and preventive medicine.*

The following programs attempt to address the shortages of trained public health professionals in the U.S.

I. Institutional Support (Capitation)

The Association of Schools of Public Health (ASPH) requests $3.0 million in FY90 funds for institutional support grants to the twenty-four schools of public health.

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* See the DHHS "Sixth Report to the President and Congress on the Status of Health Personnel in the U.S." (June, 1988)

Congress agreed to terminate this program at the end of FY90. Unfortunately, the schools face reduced state support despite the heightened demand for added manpower to meet the shortages in the field. DHHS has warned of faculty shortages in high priority areas including: epidemiologists specializing in chronic diseases, behavior and the environment; biostatisticians; environmental toxicologists, among others. Public health institutional support is used to attract qualified faculty members to the field of academic public health.

II. Student Support (Traineeships)

ASPH requests $4.0 million in FY90 funds for traineeships to students in schools of public health. The program is intended to attract high caliber students and to offer the economically disadvantaged, especially minorities, and entry point into the system. The rising cost of tuition and other expenses will make it even more difficult for low-income students, particularly minorities, to afford graduate education in public health schools.

Furthermore, traineeships are important because many students undertake graduate study in public health at mid-career and have family obligations. Others have already accrued heavy debts from their previous education. The graduates, unlike many of the other health professions, do not enjoy lucrative incomes. Nearly 80 percent of the graduates are employed by governmental agencies, non-profit organizations and universities (see attachment B). Their modest salary levels are reflected in a recent survey which showed the mean income for all 1986 graduates at $31,524 with half of the graduates making less than $28,000 (this figure includes physicians and dentists working in public health).

III. Preventive Medicine and Public Health Residencies

ASPH requests $2.5 million in FY90 funds to support residency training for students of preventive medicine and dentistry in schools of public health and medical schools. Healthy People underlined the need to increase the supply of professionals in this special practice area. Also an Institute of Medicine report, "A Manpower Policy for Primary Health Care," made several recommendations including one to increase the number of residency positions in preventive medicine. The GMENAC and COGME reports also urged support for preventive medicine training saying it was definitely a shortage area in medicine.

IV. Special Projects

ASPH requests $3.5 million in FY90 funds to support the development of training opportunities in public health to meet emerging national priorities as outlined by DHHS in the Year 2000 health objectives for the nation. This program is more focused to include projects in preventive medicine, to increase the numbers of students from disadvantaged backgrounds, and to improve access and quality of care, among others. The recently released IOM report entitled The Future of Public Health said that the schools of public health should enter into collaborative ventures with public health agencies. Special projects will allow the establishments of links between the academic and public health practice fields.

V. Prevention Centers

ASPH requests $8.0 million in FY90 funds to support a national network of prevention centers. Initiated in 1986, five centers are currently funded by CDC. They are conducting research that focuses on ways to promote good health and prevent disease. Each center works closely with local health agencies as well as with providers of health services to develop new ways of promoting health and on improved methods of appraising health hazards and risk factors. In short, they are developing state-of-the-art prevention techniques. Located in the multidisciplinary schools of public health, the centers serve as demonstration sites for translating new knowledge into practice. There is a need for additional centers. There are currently 12 approved yet unfunded centers that met the strict criteria of peer review. Needed is $8.0 million to start-up five to eight more prevention centers in FY90.

The chart on the next page outlines ASPH requests for FY90 and budget history of programs of primary concern to schools of public health.

APPROPRIATIONS (Millions)

	Final FY 1987	Final FY 1988	Final FY 1989	Pres. FY1990 Requests	ASPH Requests FY 1990[1]
Institutional Support (Capitation)[2]	$5.0	$4.7	$5.0	0	$3.0
Traineeships[2]	$3.0	$2.8	$3.0	0	$4.0
Special Projects[2]	--	--	--	0	$3.5
Preventive Medicine Residencies[2]	$1.6	$1.5	$1.5	0	$2.5
Centers for Health Promotion and Disease Prevention[3]	$1.5	$1.5	$2.0	0	$8.0

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[1] ASPH is requesting full authorization amounts.

[2] Capitation is authorized by Sec. 606 of Title VI, P.L. 100-607; traineeships by Sec. 621; special projects by Sec. 790 A; preventive medicine residencies by Sec. 788 (c). These programs are administered by HRSA.

[3] Prevention centers are authorized by Sec. 312 of Title III, P.L. 100-607. This program is administered by CDC.

ATTACHMENT A

ACCREDITED SCHOOLS OF PUBLIC HEALTH

University of Alabama at Birmingham
Boston University
University of California-Berkeley
University of California-Los Angeles
Columbia University
Harvard University
University of Hawaii
University of Illinois at Chicago
Johns Hopkins University
Loma Linda University
University of Massachusetts
University of Michigan

University of Minnesota
University of North Carolina
University of Oklahoma
University of Pittsburgh
University of Puerto Rico
San Diego State University
University of South Carolina
University of South Florida
University of Texas
Tulane University
University of Washington
Yale University

Emory University
(will seek accreditation in 1992)

State University of New York at Albany
(will seek accreditation in 1991)

ATTACHMENT B

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

HIGHLIGHTS OF THE DATA ON 1986 GRADUATES

Surveyed in February 1987
(Preliminary Results)

Employment

80.5%	of the graduates are employed
12.4%	of the graduates have continued their education
7.1%	of the graduates are unemployed

Type of Employing Organization

47.4%	of employed graduates work for tax-supported organizations such as federal, state, regional or local government and higher education institutions
33.4%	of employed graduates work for voluntary health agencies
16.6%	of employed graduates work for proprietary organizations

Types of Services Which Graduates are Providing

36.0%	of graduates are providing administrative, planning or evaluation services
17.3%	of graduates are providing clinical, laboratory, and social services
16.0%	of graduates are providing education and training or research services
6.5%	of graduates are providing public health community organizational services
11.7%	of graduates are providing consultation services

Earning Levels of Employed Graduates

50%	of employed graduates earn less than $28,000 per year

Financial Assistance During Training

51.8%	of graduates depended on traineeships, scholarships, fellowships, grants, loans or employed subsidation as the primary source of funds for meeting educational expenses

Education Related Indebtedness

62%	of graduates reported some amount of education related indebtedness. The mean indebtedness for all graduates (including those reporting no debt after graduation) was $8,142.

STATEMENT OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

This statement is presented on behalf of the Association of State and Territorial Health Officials, an organization that represents the health commissioners of each state and territory in the United

States. This statement records the Association's support for the programs and work of the Centers for Disease Control, especially work within the Prevention Block Grant Program.

Departments of Health throughout the nation are the prevention and health protection arms of Government. They prevent illnesses and early death and that prevention SAVES the nation money. This is a critical point to remember during this time of budget constraints because "a stitch in time does truly save nine."

First, let's talk about the human side of what we do; healthy babies born to women with good prenatal care, children and families saved from the tragedy of lead poisoning, phenylketonuria, hypothyroidism, children given a second chance because their parents are in a drug treatment program; families of disabled children receiving case management and services which provide the opportunity for as near-normal a life outside as possible of institutions. The human tragedy that we prevent or lessen is real. It effects real people, it cuts across race, gender, generation, geography.

Secondly, as to cost, now is not the time to retreat from efforts that save human tragedy, and which save money. We will pay now or we will pay much much more later. Prevention has to be the clarion call. PREVENTION SAVES LIVES AND SAVES MONEY.

The state health departments have been active partners with the CDC in disease prevention, lending support to and being supported by the programs of CDC. While our successes have been many, we still have much to do to prevent and control the diseases that are afflicting so many in our population. Although the President's budget has maintained or modestly increased some important health programs, its overall vision for this nation's public health needs falls short of reasonable expectations.

The Prevention Health and Health Services Block Grant is the backbone of public health and the only source of funding for prevention activities with which states can address the special needs of its citizens. The Prevention Block Grant provides the flexibility needed to target specific populations, and to create new and innovative programs that can affect health outcomes. In fact, in many states, these resources represent virtually the only source of preventive health programming that can be tailored specifically to the needs and problems of States and Communities in order to allow them to address their health problems as they see fit.

ASTHO believes it is important to underscore the critical and central role that a expanded Preventive Health and Health Services Block Grant Program can play in improving and protecting the health of individuals, families, and communities across the nation. While Federal funds account for approximately one-third of state and local health department expenditures, only slightly more than 1 percent of these expenditures support the Preventive Health and Health Services programs. State and local resources for disease prevention and control far outstrip federal support in many program areas, for example, tuberculosis control, epidemiology, chronic disease, cancer control, and renal disease. However, the Prevention Block Grant represents a significant source of funds for particular programs, for example, rape prevention, hypertension control, health education and risk reduction, rodent control, and cardiovascular risk reduction. All of these are especially important in poor and minority communities where rates of chronic illnesses are higher than in the general population. Injury prevention and occupational health are also reliant on the Prevention Block Grant and represent a important focus on a preventable problem that affects everyone. However, this support is just not enough and our activities need to be greatly enhanced if we are to make a significant impact.

It is crucial that federal funding for the Prevention Block Grant be increased beyond 1 percent of state public health expenditures in order that prevention activities can be expanded, that states can undertake additional public health intervention techniques, and so that unmet needs among target populations can be addressed. ASTHO recommends an appropriation of $130 million for the Prevention Health and Health Services Block Grant. ASTHO also requests that the TB, DM, injury control and prevention programs not be folded into the Prevention Block and that they continue to be individually funded so as to not diminish their importance as individual health concerns.

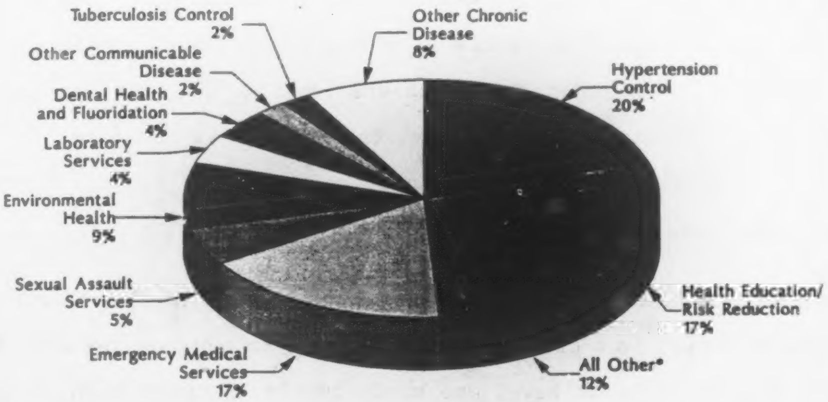
This statement of the importance of the Prevention Block Grant Program may seem like an exaggeration to many who are unfamiliar with this program. The total funding level of less than $100 million authorized and $93 million appropriated in recent fiscal years, along with the dissipation of constituency and interest groups that resulted from the establishment of the block grants in the early 1980's, may give the appearance that this particular program is a small, unfocused and ineffective federal health initiative. However, nothing could be further from the truth. While the overall level of funding is low, the states do offer as many services to their citizens as feasibly possible. And while the funds are used differently from State to State, resulting in no single rallying point for those who realize the benefits and impacts derived from these dollars, the message is the same: these Preventive Block Grant Funds buy critical services for our constituencies.

Expansion of the Prevention Block Grant appropriation level to $130 million annually is a critical need in order to advance our efforts at the state and local level and truly impact on the health status of individuals, families and communities that we all serve.

SUMMARY OF ASTHO RECOMMENDATIONS

Program	1989 Appropriation ($ Million)	President's Budget ($ Million)	ASTHO Recommendation ($ Million)
Prevention Block Grant	85.0	113.0	130.0
Sexually Transmitted Diseases	78.8	79.0	172.0
Immunization	138.7	134.8	183.7
TB Control	7.0	7.0	15.0
Lead Control	---	---	22.0
Diabetes Control	4.0	4.0	5.0
Injury Control	10.0	10.0	50.0
MCH Block Grant	554.0	554.0	661.0
Office of Disease Prevention and Health Promotion	4.44	4.49	5.0
NIOSH			
-- Research	60.0	41.0	60.0
-- Training	10.0	3.0	10.0

FIGURE 4.
EXPENDITURES OF PREVENTION BLOCK GRANT FUNDS, BY TYPE OF SERVICE, FY 1987



TOTAL: $89 MILLION

* Includes home health services, administration, and various local health services.

Source: PUBLIC HEALTH FOUNDATION *March 1989*

STATEMENT OF JAMES P. PRESLOCK, PH.D., CHAIRMAN, PUBLIC AFFAIRS COMMITTEE, SOCIETY FOR THE STUDY OF REPRODUCTION

My name is Dr. James P. Preslock. I am a biomedical research scientist and an Associate Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of Texas Medical School at Houston. I also serve as the Chairman of the Public Affairs Committee of the Society for the Study of Reproduction. Our Society is an international biomedical research society with a specific interest in basic and clinical research in the reproductive sciences. Our Society members are the holders of M.D. or Ph.D. degrees and serve on the faculty and staff of many major medical schools, research institutions, and undergraduate colleges and universities throughout the United States, and throughout 71 nations worldwide. The professional careers of our members are determined by the federal funding for the reproductive sciences as administered through the National Institute of Child Health and Human Development (NICHD), a component Institute of the National Institutes of Health (NIH). The NICHD is the primary Institute within the NIH responsible for the funding of both basic and clinical research in the reproductive sciences.

Our Society is alarmed by the severe negative impact on the funding of research in the reproductive sciences if the President's Budget for the NICHD for fiscal year (FY) 1990 is adopted by Congress. The President's Budget would substantially decrease the number of, and the dollars allocated for, new and competing renewal research grants funded by the NICHD during FY 1990. The President's Budget of $444.193 million proposed for the NICHD for FY 1990 would decrease the number of new and competing renewal grants from the current (FY 1989) level of 439 competing grants ($76.120 million) down to only 352 competing grants funded during FY 1990 ($68.016 million). Of the grants which are approved for funding, the funding rate will be up to only the 19.7 percentile with negotiated reductions of approximately 10.2%. Although the NICHD is currently funding up to only the 16.1 percentile, it is projected to fund up to the 25.3 percentile during FY 1989. As a comparison, during FY 1988 the NICHD funded 450 competing grants ($76.520 million) up to the 27.0 percentile, and during FY 1987 the NICHD funded 545 competing grants ($77.910 million) up to the 35.6 percentile.

The President's Budget for FY 1990 would maintain the number of centers within the NICHD at 46 ($33.206 million), but with negotiated reductions of 17.5%. For non-competing grants, the President's Budget would support 1,119 grants ($204.789 million), but will require negotiated reductions of 14.2%. The NICHD is currently (FY 1989) funding 1,078 non-competing grants ($183.849 million) with negotiated reductions of 12.0%. Furthermore, the President's Budget does not provide for any future growth in the reproductive sciences, since the number of individual and institutional trainees which will be supported by the NICHD during FY 1990 will remain at 633 ($15.176 million). For the NIH overall the President's Budget would decrease the number of competing grants from 5,324 for the current fiscal year down to only 4,819 competing grants funded during FY 1990. The NIH funding rate would decrease from the current 29.3 percentile to 24.4 percentile. Negotiated reductions would vary by Institute but would be at approximately 9.5% overall for the NIH. As a comparison, during FY 1988 the NIH funded 6,213 competing grants up to the 35.3 percentile, and during FY 1987 the NIH funded 6,447 competing grants up to the 38.3 percentile. Significantly, for the first time in nearly a decade the NIH will fund fewer than 5,000 competing grants during FY 1990 if the President's Budget is adopted.

In addition to the detrimental effects of the President's Budget upon research project grants and upon training, there are other programs which would be adversely affected. The President's Budget would prevent any expansion in the number of centers within the NICHD, including centers for reproductive studies, mental retardation and learning disabilities. The President's budget would also prevent the establishment of a Reproductive Medicine Network to study infertility, endometriosis, and premenstrual syndrome, in addition to studies of premature labor and low birth weight. Although Congress requested the development of a five-year plan for studying Sudden Infant Death Syndrome (SIDS), the implementation of this plan may not proceed under the constraints imposed by the President's Budget.

In our judgment, and as detailed above, the President's Budget proposal of $444.193 million for the NICHD for FY 1990 would have a serious detrimental impact upon a vital branch of biomedical science and upon the members of our scientific society. The Society for the Study of Reproduction has therefore adopted and is supporting the Professional Judgment Budget for the NICHD which is also being supported by other scientific and behavioral societies which are directly affected by the Congressional funding for the NICHD. The Society for the Study of Reproduction is supporting a budget of $584.632 million for the NICHD for FY 1990. This budget would permit funding of 537 competing grants ($113.773 million) including 35 for AIDS research ($12.250 million), with funding up to the 30.0 percentile, and with no negotiated reductions. This budget would also permit the full cost funding of 1,119 non-competing grants ($238.116 million) including 22 for AIDS ($6.994 million), and would increase the number of centers within the NICHD from the current level of 46 ($33.613 million) up to 50 ($44.200 million) with no negotiated reductions. This budget would also increase the number of individual and institutional trainees within the NICHD from the current level of 633 trainees ($14.663 million) up to 858 ($20.503 million). We believe that this budget would provide for a reasonable and justifiable growth for the NICHD in light of the constraints imposed by the Gramm-Rudman-Hollings Budget Reduction Act.

In general terms this budget of $584.632 million for the NICHD for FY 1990 would provide increased research grant funding for developing newer, more effective and safer contraceptives to decrease the rate of unwanted pregnancies, particularly among teenagers; for investigating the causes of and developing treatments for infertility, a reproductive disorder which results in the inability of one in six couples to have children; for investigating other disorders of the reproductive system including endometriosis and premenstrual syndrome; for investigating reproductive mechanisms inherent in menopause and its associated problems including osteoporosis; for investigating the mechanisms involved cancers of the reproductive system including ovarian, uterine and breast cancer in the female, and prostatic and testicular cancer in the male; for studying how to prevent premature labor, low birth rate and infant mortality; for establishing networks for cooperative clinical research in reproductive medicine; for conducting AIDS research; and for investigating basic molecular and genetic mechanisms involved in the function and regulation of the female and male reproductive systems. This budget would also provide for an active SIDS program within the NICHD, and for the study of birth defects including spina bifida. The President's Budget, if adopted, would seriously impede progress in all of these critical areas.

The budget which we are supporting for the NICHD for FY 1990 would assist greatly in alleviating the chronic problem of the underfunding of the NICHD as an Institute of the NIH. The NICHD has consistently been among the lowest funded of all Institutes within the NIH. The NICHD has consistently funded the lowest percentage of competing grants per year during the last six fiscal years, and with the least dollars awarded per each grant funded among the seven major Institutes within the NIH. For example, the President's Budget for FY 1990 would result in a funding level up to the 24.4 percentile for approved grants for the NIH overall, while for the NICHD the President's Budget would fund up to only the 19.7 percentile of approved grants. The budget which we support for the NICHD would begin to reverse this chronic underfunding of the NICHD.

For the NIH as a whole the Society for the Study of Reproduction supports the Professional Judgment Budget of $9.201 billion (excluding AIDS) which will fund 8,307 competing grants($1.718 billion) with no negotiated reductions and at a funding level up to the 30 percentile for approved grants. This budget would also increase the number of trainees from the current level of 10,206 trainees ($252.806 million) up to 12,300 trainees ($302.082 million) for the NIH for FY 1990. The number of centers would increase from the current level of 572 centers ($551.688 million) to 704 ($806.568 million).

Thank you for your consideration of our request.

STATEMENT OF LASALLE D. LEFFALL, JR., M.D., FORMER PRESIDENT AMERICAN CANCER SOCIETY

The American Cancer Society is pleased to present a proposal for FY 1990 for the National Cancer Institute "Citizen's Budget" on behalf of the American Cancer Society, the world's largest voluntary health agency -- over 2 million active volunteers.

I am Dr. Lasalle D. Leffall. I am a Former President of the American Cancer Society, and an Honorary Life Member of the National Board of Directors. In addition, I am Professor and Chairman of the Department of Surgery of Howard University College of Medicine.

Each year the American Cancer Society (ACS) recommends to the Congress a "Citizen's Budget" figure for the National Cancer Institute for the coming fiscal year. Traditionally, this figure has represented the best judgment of the American Cancer Society regarding that portion of our country's national resources which we believe our government should dedicate to the battle against cancer.

Characteristically, our figure has been considerably higher than that recommended by the President in his annual budget message. While the American Cancer Society's annual recommendation has been higher, it has, in every instance, represented our attempt to be practical and responsible, and at the same time, be realistic concerning the amount of funding necessary to fight cancer during that year.

The American Cancer Society has come before the Congressional appropriations subcommittees to speak on behalf of the American people about the National Cancer Institute appropriation for nearly forty years. We come before Congress because we represent the non-governmental, private sector element in the battle against cancer.

Our nearly two and one-half million volunteers serve the people of this nation in every state, county and community, at no cost to the government. All American Cancer Society funds are raised privately from the American people. The American Cancer Society receives no government funds of any kind.

Support of cancer research is one of our major activities. In 1988, The American Cancer Society provided nearly $100 million in support of investigator-initiated, peer reviewed research. Additionally, we allocated over $62 million of our voluntarily donated funds to public education; over $71 million to patient and community services; and almost $33 million to professional education.

The American Cancer Society is the largest single source of private, non-commercial funding for cancer research and control. We feel that our organization, experience, and expertise in the field of cancer uniquely qualify the American Cancer Society to serve as the non-government authority in this area.

A year ago, American Cancer Society President, Dr. Harmon Eyre, presented our recommendation for the 1989 NCI appropriation -- $2.080 billion. The actual budget received by NCI fell woefully below that figure -- $1,571,460,000, which included $122.8 million earmarked for AIDS research.

That made the NCI non-AIDS cancer budget only $1,390,500,000. At this time it appears as though the final figure which will be received by NCI for FY '89 will actually be less than the President's budget required, and less than that recommended by this committee. We are very concerned about this because we cannot recall any other year when NCI received less than the President's budget request for that year.

This year, the Administration budget requests $1,494,700.00 for the cancer (non-AIDS) portion of the NCI appropriation, with an additional $151.2 million for AIDS -- for a total proposed NCI level of $1,646,073,000.

The American Cancer Society applauds and congratulates the Congress, and particularly, this subcommittee, its leadership and its members, for your foresight and your sensitivity to the continuing importance of cancer research and control through your realistic appropriations for the NCI.

But the battle against cancer has reached a crucial stage. While appropriations have been increasing in recent years, they have not been able to keep up with the potential momentum in cancer research progress.

The American Cancer Society believes that FY '90 will be the year of dramatic, significant advances against cancer. Because of this, we are recommending a Citizen's Budget of $2,195 billion for NCI for FY '90. This figure represents a significant increase over the President's budget for FY '90, but we believe it is fully justified and realistic considering the opportunities and the potential. We are convinced it is an amount that will be well spent. Also, we believe it is a small investment promising giant returns in the cancer battle which is costing the federal treasury more than $65 billion each year in lost wages, increasing cost of treatment, lost tax revenue, and human suffering.

Research, both basic and clinical remains the key element in progress against cancer. We believe that the most compelling argument for higher funding is the urgent need to increase the percentage of approved research grants. Approval of these grants is based on peer review. By approving them, their scientific peers determine that they are vitally needed to add knowledge to our search for better understanding of the mysteries of cancer.

A key reason for the American Cancer Society's support of the NCI Directors' Bypass budget for FY '90 is to achieve our recommendation of 50% funding of approved research grants.

As of 25 May, it looks as though NCI will see one of the smallest annual increases since the National Cancer Law enactment in 1971 -- only 26% of approved grant applications are estimated to be funded.

The chart shows the history of research grant funding over the past 17 years, and 1989 shapes up as being the lowest. We all have our sights set on the year 2000 as the target for a massive reduction in cancer incidence and mortality. We believe that target -- only 10 years away -- is still realistically attainable if adequate resources are allocated and applied.

Inevitably, a tremendous number of good, important ideas are not being followed up as a result of the current low level of research funding. It is difficult for a group of scientists, reviewing research applications, to predict exactly the source of the best ideas. The clue to the critical information which might move us quantum leaps ahead could be lying among the grants we have not had the money to fund.

Even now, ideas are exploding in the basic cell biology of cancer and its mechanisms. We are learning about oncogenes, their cancer causing expressions and how they control cell behavior.

Recent research has brought us closer to understanding chromosonal abnormalities. In one significant case, it has been demonstrated that deletion of a repressor gene from a chromosome is a necessary step in the function and activation of an oncogene. Further developments like this in cell biology reached through research will lead to our ability to control cancer.

The development of man's ability through modern biotechnology, to produce large quantities of identical substances such as biological response modifiers, or drugs that have been in sparse supply, has significantly improved the potential for effective cancer therapy.

Advances in understanding the way cells develop resistance to drugs would significantly improve the effectiveness of chemotherapy. Development of new applications of known, effective drugs would broadly expand our treatment resources.

Undeniably, exciting, significant progress is being made against cancer -- and that progress is clearly tracked from implementation of the National Cancer Program. But definable progress also reveals where the next generation of challenges are: we've made dramatic progress against cancer in people under sixty-five years of age -- testicular cancer, Hodgkins disease, leukemia, cancer in children under 15 years, uterus, bladder, stomach -- even pancreas and breast cancer. But our progress has not been so positive in the elderly. Cancer in the older population requires renewed emphasis and more vigorous attack.

The one cancer that continues to cause more deaths than all others is lung cancer -- a preventable cancer. The entire slate of man's effort against cancer would show great achievement and encouragement were it not for the distorted picture presented by this, which has the highest incidence, yet is most preventable of all cancers.

In 1988 we came before this Committee expressing our concern about the deteriorating infrastructure of cancer research facilities. We regret to report that the situation continues to worsen, and we believe it is at a critical stage. Our 1985 study of construction needs predicted that by 1990 all areas of cancer research would be experiencing overcrowding and the need for additional space would be critical. That time is upon us. We firmly believe that if improvements are not made, and additional space is not acquired, the National Cancer Program will be hindered by its inability to expand current research, and to develop new programs to meet its year 2000 goals.

Again, we strongly urge higher funding for NCI to include at least $20 million for research facility construction and renovation, together with appropriate authorities to spend those funds.

When NIH Director, Dr. Wyngaarden appeared before The House Appropriations Subcommittee recently, Chairman Natcher asked him a very important and thought provoking question -- he asked him how he would allocate $500 million, if the NIH appropriation were to be increased by that amount.

If the American Cancer Society is allowed a bit of editorial license with that question, we would like to offer some thoughts as to how we would recommend that approximately $200 million of an additional $500 million might be applied to the National Cancer Program.

We have reviewed NCI public documents, talked to our colleagues at the Institute, and asked a lot of questions. We have tremendous respect for NCI leadership, and believe the 1990 bypass budget is an accurate reflection of the needs for next year's opportunities.

But, we also realize that the full $2,195 billion indicated in the bypass budget is unlikely to be realized. So we offer recommendations for programs and projects which we believe would be possible if you recommended approximately $200 million more than the President's request. A sizeable portion of this -- we would recommend half -- should go for research project grants. We believe an additional $100 million for research grants would bring the percentage of approved grants funded to nearly 40% -- a dramatic turn around from 1989.

We support a sizable portion of the remainder to go to cancer centers. In the current year we are programmed to lose five comprehensive cancer centers. Unless the trend is reversed, there are likely to be five fewer in FY 1990.

Cancer centers are critical to our National Cancer Program. We cannot afford to lose any, much less 10.

Cooperative clinical research support is ebbing. Clinical trials, where the latest newly developing treatments are tested in man, are the principal mechanism for moving cancer research progress from the laboratory to the patient -- this activity needs an increase in funding.

Cancer prevention and control has the potential for the biggest payoff in lives saved. NCI is especially concerned about the accrual of patients into the community, clinical oncology programs (COP). Increased funding here would allow increased minority involvement in this program.

Additional funding is vitally needed for training, because the pool of highly trained research investigators continues to drop as fewer approved grants are funded.

We hear from various sources at NIH that NCI's supercomputer is in need of capacity expansion. Additional funds here would provide a needed resource not only for NCI, but for the entire biomedical research community.

Other programs which stand out as needing additional funds, over and above the President's budget request are research and development contracts to make possible expansion of chemoprevention studies, drug development, carcinogenisis, and increased support for epidemological activities in the SEER program. The PDQ system, as well as the Cancer Information Service programs deserve additional funds.

I'd like to make one additional comment. The American Cancer Society and the NCI share another, most important concern -- that of the problem of cancer in the underserved. We at ACS call this our initiative to address the problem of cancer in the nation's socioeconomically disadvantaged. Our National President, Dr. Harold Freeman, Chairman of the Surgery Department at Harlem Hospital in New York City, has taken this objective as the theme of his Presidency. In order to gain a clear understanding of the extent of the problem of access to cancer care among the 37 million Americans who are without any medical insurance, The American Cancer Society is conducting a series of seven public hearings in various sections of the United States this spring. The results of these hearings will be presented in a special "Report to the Nation" here in Washington on July 17.

Thank you for the privilege of presenting the testimony of The American Cancer Society on the FY '90 National Cancer Institute appropriation.

STATEMENT OF WILLIAM A. PECK M.D., NATIONAL OSTEOPOROSIS FOUNDATION

Mr. Chairman, I want to thank you for the opportunity to submit written testimony on the issue of increased funding for research on osteoporosis. On behalf of the thousands of members of the National Osteoporosis Foundation (NOF) and the many scientists, health professionals and consumers concerned about osteoporosis, **we urge you to markedly enhance the amount of funding for osteoporosis research to between $50 and $60 million.** Funds should be allocated to the National Institute on Aging, the National Institute on Arthritis and Musculoskeletal and Skin Diseases, and the National Institute of Diabetes, Digestive, and Kidney Disorders as the principal institutes charged with research on osteoporosis.

Osteoporosis is one of the nation's most significant health problems, affecting between 25 and 30 million people, mostly older men and women. This condition is characterized by the excessive loss of bone tissue which leads to fractures most typically of the hip, wrist, and spine. Osteoporosis is known as the "silent thief," the end result of a generally painless, gradual loss of bone tissue accompanying aging.

Annually, osteoporosis is responsible for 1.3 million bone fractures, or 70 percent of all fractures in people over age 45. Each year, about 250,000 hip fractures, 500,000 fractures of the vertebrae, 200,000 fractures of the wrist, and another 200,000 fractures at other limb sites are attributed to osteoporosis.

Hip fractures are the most debilitating outcome, resulting in lost independence, suffering, increased mortality, and substantial financial expense. Approximately 15 percent of elderly hip fracture patients will die within one year of sustaining the fracture and over 50 percent of the survivors will be permanently disabled, no longer able to live independently. For many, hip fractures will lead to permanent institutionalization in a long-term care facility.

The yearly cost of osteoporosis to our nation is estimated to be $10 billion, a figure that has grown rapidly and is expected to grow to $30 billion by the end of the century as the older population increases in number. Efforts to thwart this mounting public health problem must be undertaken now if we are to prevent osteoporosis from reaching epidemic proportions. One can readily imagine the destructive impact of osteoporosis that will be felt by society in the future if the development of this condition remains unchecked.

We believe that a concerted attack on osteoporosis is overdue and cannot wait until the next generations of women and men develop this devastating condition. We must, today, declare a crusade against osteoporosis in order to assure sufficient support for funding a full complement of investigator-initiated research.

It has been estimated that for every $1 invested in medical research, there is a $13 return on the investment as a result of improvements in absenteeism, increased productivity, and diminished health care costs. Both in economic and human terms, research into osteoporosis is cost effective; yet, today we spend only one-eighth of one percent of the cost of osteoporosis on research. Even in times of tight budget constraints, such as those we are experiencing today, the short-term cost of research as compared to the long-term gain must not be overlooked.

Some of our most respected researchers believe that we are close to achieving important breakthroughs in our ability to understand osteoporosis. Only in the last two years we have found estrogen receptors in bones, thus providing a tantalizing clue to the use of estrogen in protecting against bone loss and giving us a window on potential treatments. Also, estrogen antagonists that are used for treatment of estrogen-dependent tumors (breast and uterus), were found to have estrogen-like effects on bone. Thus, other antiestrogens may be developed that prevent bone loss but lack some of the side effects of estrogen.

Recently, also, we have discovered bone growth promotion molecules within bone tissue, molecules that can be harvested for use in treating osteoporosis.

Discoveries of these types are critical but they require a commitment to funding research that can only be made at the federal level.

We believe that osteoporosis is essentially preventable but that further research is needed to determine the extent to which lifestyle decisions can affect the development of this condition. If proven to be preventable, it will be possible to greatly reduce the prevalence of this condition in future generations.

The National Osteoporosis Foundation is the only voluntary health organization dedicated to education and research into osteoporosis. In that capacity, NOF currently administers the only privately funded research into this condition. Based on that experience, it is clear that the ability to address research of the scope required cannot be funded by the private sector alone. The need is too great.

Thus, on behalf of the millions of individuals with osteoporosis and their families, we urge you to take a strong stand by making a commitment commensurate with the magnitude of this public health threat. Consistent with that view, we urge that research be targeted into the four principal areas as identified in the 1984 Consensus Development Conference on Osteoporosis sponsored by NIH:

1) Basic, epidemiological and clinical studies to determine the mechanisms of and risk factors for osteoporosis and to predict responses to intervention;

2) Studies to expedite the improvement of existing methods for measuring bone tissue and for developing newer and less expensive approaches;

3) Studies to develop safe, effective, and low cost approaches for preventing osteoporosis; and

4) Studies to cure osteoporosis.

Again, I want to thank you for the opportunity to express our views on these issues of great concern.

STATEMENT OF THE AMERICAN FEDERATION FOR CLINICAL RESEARCH

The American Federation for Clinical Research (AFCR) is pleased to have this opportunity to comment on funding for the NIH. The AFCR is the nation's largest organization for medical investigators. It is comprised of more than 13,000 physician and non-physician scientists who are engaged in virtually every area of medical research. Our membership includes many distinguished medical scientists -- among them, winners of the Nobel Prize in Medicine.

The programs of the National Institutes of Health (NIH) are of special importance to the AFCR membership. Most of our members are based in universities and receive funding for their research from the NIH extramural program. The AFCR's interest in the NIH is focused particularly on funding for: 1) investigator-initiated research project grants; 2) the National Research Service Awards (NRSA) program for the training of new investigators; 3) career development awards, and 4) the General Clinical Research Centers program.

The AFCR appreciates the Subcommittee's leadership in advocating increased Federal funding for bio-medical research. During the last eight years, you refused to accede to Administration attempts to limit NIH spending growth and delay the expenditure of appropriated funds. You sought to defend the health research agencies' share of Federal R&D spending at a time that the Administration was succeeding to target Federal science support to the military as shown in Attachment 1. In so doing, you responded to the wishes of tax-paying Americans, 82% of whom believe government spending for health research should increase and 73% of whom believe military research spending should be reduced or held constant (see Attachment 2). In short, the AFCR is grateful to you for protecting the NIH budget, for refusing to condone an irrational science spending policy, and for responding to public support for our efforts.

OVERALL RECOMMENDATION

The AFCR supports the proposal of the Ad Hoc Group for Medical Research Funding, which recommends an FY 1990 NIH budget of $8.4 billion to fund existing programs and an additional $427 million to support facilities construction. These proposed increases over the current year may seem unrealistic given the need to reduce the Federal deficit. However, we believe that the proposal can be convincingly defended for several reasons:

- First of all, scientists from many fields have acknowledged that biomedical research is today the singly most promising area of science.
- Second, as noted above, the current R&D budget, which provides $40 billion to military research and less than $8 billion to health research, is inversely related to the views of the majority of American taxpayers and should be realligned. Unfortunately, the Bush Administration's science budget would continue funding at roughly these levels and thus appears to be based on neither scientific expertise nor public preference but rather political considerations. We realize that this

Subcommittee does not control the budget for military research. However, we hope that you will work with your colleagues on the Budget Committee to assure a more sensible allocation of Federal science dollars.

- Finally, the investment in health research has economic advantages. Attachment 3 provides examples of how innovations in medical care resulting from NIH-supported research can achieve major health care and disability cost savings. For example, a 4-year research project costing only $680 thousand yielded information that is expected to translate into health cost savings of a minimum of $300 million per year. AIDS provides another example in this regard. What kind of budget for AIDS treatment would be necessary today if we had not identified the AIDS virus and developed a test to screen the blood supply? Absent that discovery, additional tens of thousands of adults and children receiving blood transfusions would have been infected. In short, health research not only saves lives. It saves money.

PRIORITIES FOR NIH

Within the recommended budget of $8.4 billion, the AFCR believes that the following efforts should be given priority consideration:

- Research Training: Of special importance to our organization, an increase of $50 million over the current year would allow the NIH to support 11,800 trainees at the increased stipend levels recently implemented. Last year, in testimony presented before the Subcommittee, the AFCR recommended that training stipends be increased. Subsequently, we supported the NIH in taking the initiative to raise stipends despite the fact that this would necessitate a reduction in the number of trainees supported. This year, we hope that you will provide the funding necessary to maintain the new stipend levels and support the number of trainees recommended by the National Academy of Sciences.

- Investigator-Initiated Awards: An increase of $1 billion over the current year is necessary to allow the NIH to fully fund one out of three competitive grants in FY 1990 and to allow full funding for non-competing renewal grants. The AFCR considers it critically important that steps be taken to avoid the across-the-board cuts that are currently being imposed on NIH grants. The quality of science funded by the NIH is compromised when the agency must cut grants by as much as 15% despite the fact that the costs of biomedical research supplies and equipment continue to increase dramatically.
- General Clinical Research Centers: An additional $9 million over the current year would enable the NIH to provide full support for 78 General Clinical Research Centers (GCRCs), the number supported during the current fiscal year. GCRC grants support specialized facilities -- usually organized as separate units within hospitals -- for the conduct of patient-oriented research. Research conducted in these centers is aimed at identifying how basic research discoveries can be applied to improve the care of patients. In addition, the GCRC's offer a first-hand view of the rewards of research careers to medical students training in host institutions.
- Career Development Awards: An increase of $21 million over the current year would allow the NIH to increase the number of research career awards by 250. These grants are of particular importance. Studies have shown that because the competition for investigator-initiated grants is so fierce (for physician researchers in particular), it is not unusual for years to elapse between the completion of research training and the receipt of a first research project grant. NIH career development awards are essential to support the research efforts of newly-trained researchers and to enable them to make the transition to successful careers as investigators. Without such mechanisms of support, many young

researchers would be forced by financial necessity to forego research careers.

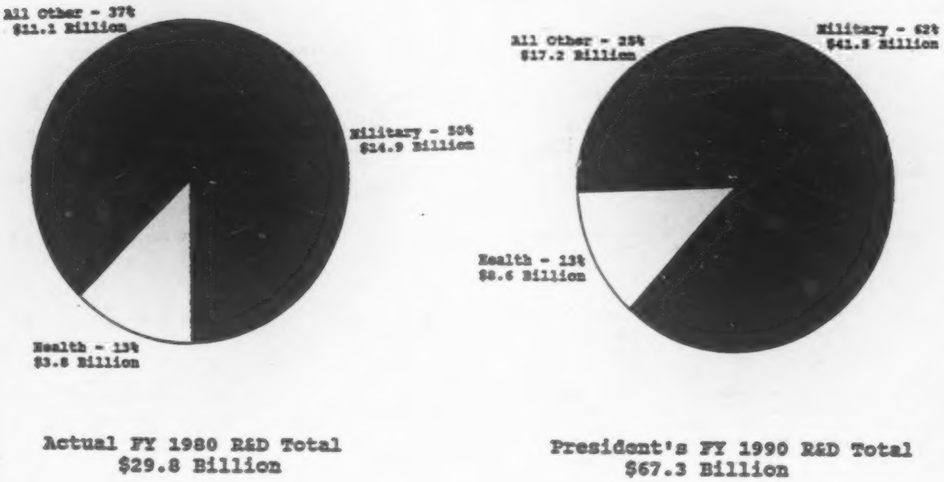
CONCLUSION

The AFCR is pleased to present its views regarding FY 1990 funding for the National Institutes of Health. Our organization recommends funding at a level of $8.4 billion to support current NIH programs and an additional $427 million to fund facilities construction. We believe that this is a reasonable request in light of the opportunities that exist in our field, public sentiment, and the economic benefits made possible by research. Further, we suggest that if Federal research priorities are realligned, funding at this level can be accomplished without exacerbating deficit spending.

We appreciate your consideration of our views.

Attachment 1

FEDERAL RESEARCH & DEVELOPMENT BUDGET



Attachment 2

PUBLIC OPINION POLL
CONDUCTED SEPTEMBER 9-10, 1989
BY OPINION RESEARCH CORPORATION
FOR THE AMERICAN FEDERATION FOR CLINICAL RESEARCH

Because the government is limiting spending for its research programs, priorities must be set carefully. It may be necessary to cut funding for some research programs in order to increase funding for others. Would you like to see government funding increase, decrease, or remain the same for research aimed at:

	Increase		Decrease		Remain Same		Don't Know	
	#	%	#	%	#	%	#	%
Exploring space	267	27	256	25	400	40	85	8
Improving health	824	82	23	2	128	13	33	3
Using energy more efficiently	666	66	61	6	230	23	51	5
Improving weapons	206	20	371	37	360	36	71	7
Reducing pollution	761	76	53	5	160	16	34	3

Which one of these research goals would be your top priority?

#	%	
43	4	Exploring space
533	53	Improving health
69	7	Using energy more efficiently
28	3	Improving weapons
300	30	Reducing pollution
35	4	Don't know

Examples of Health Care Cost Savings Resulting From NIH-Supported Research

BID	HEALTH CARE ADVANCE	TYPE OF SAVINGS	ESTIMATED AMOUNT AND DURATION OF NIH APPLIED AND CLINICAL RESEARCH SUPPORT (Millions)	ESTIMATED REALIZABLE ONE-YEAR SAVINGS (Millions)^1	EXPLANATORY NOTES
NHLBI	Compare Advantages of Medical vs. Surgical Treatment of CHD	Reduce Cost of Treatment	$27.0 (1973-1984)	$258.0 - $516.0	A,N
NHLBI	Antenatal Steroid Therapy to Prevent Neonatal Respiratory Distress Syndrome	Reduce Cost of Treatment	$5.5 (1976-1983)	$10.6 - $93.1	B,N
NHLBI	Improved Preparation of Blood for Transfusing Cooley's Anemia Patients	Reduce Cost of Treatment	$0.39 (1983-1986)	$1.8 - $2.6	C,N
CC	Orthosis for Joint Dysfunction	Reduce Cost of Treatment	$0.37 (1984-1986)	$13.4 - $26.7	D
CC	Salvage Previously Unusable Blood	Reduce Cost of Treatment	$0.016 (1983-1984)	$1.0 - $2.0	E
NIAID	Hepatitis B Vaccine	Prevent Acute/ Chronic Illness, reduce health care utilization	$23.5 (1964-1981)	$47.3 - $94.7	F,N
NIAID	Varicella Vaccine to Prevent Chicken Pox in Immunocompromised Children	Reduce Cost of Treatment	$1.8 (1979-1986)	$5.4	G
NINCDS	Plasmapheresis for Guillain-Barre Syndrome	Reduce Cost of Treatment	$3.3 (1981-1984)	$18.1 - $36.2	H,N

Examples of Health Care Cost Savings Resulting From NIH-Supported Research (continued)

BID	HEALTH CARE ADVANCE	TYPE OF SAVINGS	ESTIMATED AMOUNT AND DURATION OF NIH APPLIED AND CLINICAL RESEARCH SUPPORT (Millions)	ESTIMATED REALIZABLE ONE-YEAR SAVINGS (Millions)[1]	EXPLANATORY NOTES
NINCDS	Compare Alternative Methods of Treating Ischemic Cerebral Vascular Disease	Reduce Cost of Treatment	$9.0 (1977-1985)	$13.8	I
NCI	2-stage Diagnosis/ Treatment of Breast Cancer	Reduce Cost of Treatment	$10.6 (1971-1986)	$168.9 - $337.9	J
NEI	Laser Photocoagulation Treatment of Diabetic Retinopathy	Arrest Disabling Chronic Disease Process, reduce earnings loss, custodial and rehabilitation expense	$48.2 (1971-1986)	$2,300.0 2,3/	K
NICHD	Mass screening for Neonatal Hypothyroidism	Prevent Disabling Chronic Disease, reduce earnings loss, custodial and special education expense.	$1.2 (1979-1986)	$206.2 3,4/	L
NIDDK	Prevention of Recurrent Kidney Stones	Reduce Cost of Treatment	$.68 (1980-1984)	$299.8 - $599.7 3/	M,N

1/ Where a range is given, estimates are based on illustrative 50 percent and 100 percent adoption rates. Numbers should not be added to obtain a column total.

2/ Present Value of cumulative $2,800 million savings over five years, discounted at 6 percent.

3/ Includes estimate of earnings that would otherwise be lost.

4/ Present Value of cumulative $625 million cost savings over first 65 years of age of first-year cohort, discounted at 6 percent.

STATEMENT OF C. RONALD KAHN, M.D., THE JOSLIN DIABETES CENTER

I am C. Ronald Kahn, M.D., Research Director of Joslin Diabetes Center and Mary K. Iacocca Professor of Medicine at Harvard Medical School. I appreciate the opportunity to submit testimony on behalf of Joslin Diabetes Center for increased funding of biomedical research. While we believe that the National Institutes of Health budget should be doubled, we support the Ad Hoc Group for Biomedical Research Funding in recommending that at least $8.4 billion be directed to programs of the NIH as a first step in that direction. Likewise we believe that the budget of the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) should be approximately two times its present level if biomedical research is to progress at a reasonable pace. Again, the NIDDK Director's recommendation of $577,235,000 would be a minimum start in that direction.

Biomedical research is truly in a golden era. The advent of sophisticated biochemical and molecular techniques have allowed us to increase our understanding of disease at an unprecedented rate. Virtually every week, there are more diseases understood at a molecular level than in any decade in the first half of this century. Novel approaches to diagnosis, to therapy, and to the prevention of disease are being offered almost daily. Despite this boom of biotechnology, physicians and scientists find it increasingly difficult to obtain research funding and are under increasing pressure to justify and to prioritize competing research projects and needs. To understand this apparent dichotomy one need only look at the status of federal funding for biomedical research.

Currently in the United States about $14 billion is spent on biomedical research. Of this, about $7 billion comes from federal sources, about $6 billion from industry and a little less than $1 billion from various types of non-profit foundations and associations. The most important single source of funds is the National Institutes of Health (NIH). Over the past 8 years, the NIH has had an increase in budget from $3.2 billion to $6.2 billion. These figures are often displayed as an example of the strong support given to biomedical research, even in times when there is considerable political pressure on federal budgets. But is this in fact a reasonable amount for biomedical research, and is the rate of growth appropriate?

Certainly compared to the other major federal program, defense research, the NIH budget is truly miniscule. In fact, the increase in defense research during the past 8 years, and just the increase, is more than 3-fold the entire NIH budget. This difference is further magnified if one expresses research and development (R & D) as a percentage of total expenditures in each area. Likewise, the pharmaceutical industry, leisure time activities, the aerospace industry, the electronics industry, and the automotive industry all have R & D expenditures ranging from 3.5 to 8%. This compares to the budget for health-related R & D over the last 4 years which has averaged between 2.9 and 3.2%, barely edging out the amount of research done by the tire and rubber industry! In addition, health R & D is calculated based only on direct medical expenses and does not take into account the true economic burden created by disease.

For example, there are about 10 million people in the U.S. with diabetes. The economic cost of diabetes, i.e., the cost of medical care as well as lost potential income, is about $1400 per person affected per year. The total budget for diabetes research is a little over $200 million or only $20 per person per year, about 1.4% of the total economic burden. Similar figures can be derived for virtually all major diseases.

Despite this, physician/scientists are frequently challenged with the questions "But is biomedical research cost effective? Do we really get our money's worth? If we put more into this effort, could you guarantee greater results?"

The answer to these questions is an unequivocal "Yes". One need only open the newspaper to realize that we are curbing disease and we are living longer. In the period from 1950 to the present, the average length of life for individuals living in the U.S. has increased steadily at an average rate of 10.2 weeks per year, and there is no evidence of a plateau in sight. Thus, for every year an individual lives, there is an increase in life expectancy of 10 weeks, or to put this in business terms a 20% return on investment.

There is other ample tangible evidence for the cost effectiveness of biomedical research. The best example of recent history, of course, is the effective vaccination for poliomyelitis and other childhood illnesses. It has been estimated that in the first 6 years after the polio vaccine became available, over 150,000 cases of paralytic polio and 12,500 deaths were prevented. The prevention of these paralytic cases averted the loss of $6.3 billion of income and saved hospital costs of approximately $2 billion per year, not to mention the other medical care costs and human suffering. To put this in modern day terms, if an effective vaccine for polio had not been discovered, the cost of this disease in 1989 would be over $30 billion annually or over 4 times the entire NIH budget for biomedical research. Thus, this one discovery alone has offset the cost of all biomedical research —— past, present, and future.

There are many other points which indicate that biomedical research is indeed cost effective. These include effective treatment for most bacterial and fungal infections; a dramatic reduction in deaths due to stroke by elucidation of mechanisms of hypertension and the development of anti-hypertensive drugs; sophisticated diagnostic imaging which results in the early diagnosis of many diseases; an understanding in treatment of cardiac arrhythmias and lipid disorders resulting in reduced cardiovascular death; recombinant DNA production of proteins for human therapy as expected and commonplace, including for hormones, such as insulin and growth hormone, growth factors, and TPA; the control of gastric acid secretion in the medical treatment of peptic ulcer disease; the treatment of end-stage renal disease with dialysis and transplantation; the transplantation of other organs; and the effective therapy of many types of lymphoma and some other cancers resulting in true cures.

So if biomedical research is both underfunded and cost effective, why isn't there more? One need not think very long nor hard to come up with a list of many contributing factors: the high level of competition for funds from federal sources, the needs in many other important areas of public funding such as housing, food, and health care, and the political pressures to fund other activities, such as defense.

Many years ago, researchers established the peer review system in an attempt to use wisely the funds provided. Prioritizing biomedical research, however, does not solve the problem. No matter how well-intentioned, carefully performed, or cleverly devised the system, attempts to arrange priorities will be, and are, stifled by a system which has inadequate resources. In addition, as scientists try to establish priorities for various research projects, they give non-scientists the impression that since we have funded the highest ranking grants, there is no loss to society by not funding the others. But we should remember that this ranking does not take into account the rest of societal priorities, most of which are not so critically considered.

For example, Americans spend over $1 billion dollars a year on popcorn, over $700 million on peanuts, and about only $500 million for research in heart disease. Likewise, this year Americans spent $1.7 billion on Nintendo; by contrast the Government spent only $1.5 billion on all of cancer research. Cigarette companies spend about $1 billion a year on advertising, or between two and four times the NIH budget for all research into pulmonary diseases. And there are many more subtle, but equally devastating perverted priorities. For example, recently both scientists and the public have expressed more effort and concern over fraud and misconduct in science than in scientific process and advances. While none of us condone fraud or scientific misconduct, these are truly rare occurrences, and as most scientists realize, usually have no significant impact on scientific progress, since research tends to be self-correcting whether errors occur accidentally or knowingly. Yet we find some scientists who seem to be caught up in this frenzy, undermining public confidence, and diverting us from our true goals.

So with this as a backdrop you might ask, well what can we do? First, as a nation, we must have a commitment and an adequate budget for biomedical research. At the very least, medical research should be on par with other major technology based industries, that is, at least 6 to 7% of all health expenditures should be for research and development. To achieve this goal, we must increase funding from all sources. Of course, the major installment needs to come from the Federal government. While the NIH budget has risen steadily when expressed in current dollars, in constant dollars, that is when corrected for inflation, there has been absolutely no growth in NIH over the past 8 years. The current total NIH budget for medical research amounts to only $28 per person per year or 8 cents per person per day. If at minimum we could increase the per capita contribution by $.05 per day, there would be $4.5 billion more for research. In addition, we must find ways to tap more effectively industrial funding for biomedical research, and stimulate the growth of non-profit foundations and associations. However, even together these will not be sufficient and thus we must search for new sources of research support. Certain industries should clearly take a larger role in medical research funding, such as the health and life insurance industries which most directly benefit from the product. And as individuals live longer, life insurance companies benefit from this longevity by increased time during which they can have these funds earning interest in other investments, and health insurers want the benefits of the latest technologies for their patients. If these two industries contributed as little as 1% of their sales to R & D, there would be an additional $3.5 billion for biomedical research.

We are about to enter the final decade of the 20th century. There is no doubt that we are poised in a position never before experienced in medical research. Within our grasp are the tools and the technologies to unravel many of the important medical problems facing humankind. We have the ability and the talent. What we need are the appropriate resources and time to apply them.

STATEMENT OF H. HUGH FUDENBERG, M.D.

Subject: The Need for Increased Biomedical Research into
Chronic Fatigue Syndrome (Chronic Epstein-Barr Virus)

Mr. Chairman, I provide this testimony as a physician and biomedical researcher concerned with the disorder Chronic Fatigue Syndrome, or CFS. This disease has also been referred to in the medical literature by other names, including Chronic Epstein-Barr Virus Syndrome (CEBV), Chronic Hyperfatigability Syndrome (CHS), and Chronic Fatigue Immune Dysfunction Syndrome (CFIDS).

The 1988 Labor-HHS-Education Appropriations Bill was accompanied by a report which contained language regarding this disease. Among the recommendations contained in this report, the Committee urged the National Institutes of Health to expand research on this disease.

The CFS patient population we have seen suffers from a variety of the major symptoms outlined in the research Working Case Definition sponsored by the Centers for Disease Control for this disease: debilitating fatigue or easy fatigability, mild fever, pharyngitis, painful and tender lymph nodes, muscle weakness, muscle discomfort or myalgia, fatigue lasting more than 24 hours after exercise, headaches, arthralgia, photophobia, transient visual scotomata, forgetfulness, excessive irritability, confusion, difficulty thinking, inability to concentrate, depression, and sleep disturbances.

We tend to see some of the most severely afflicted of this patient population, who show a range of additional signs and symptoms, and are largely disabled. The most severe cases, up to one-half, are unable to work due to severe fatigability and neurological impairments. Much of this group is bedridden. Another smaller group, about one-quarter, are able to work only periodically, part-time, or on a consulting basis. All have severely restricted activity.

We suspect that the order of magnitude of Americans affected by the Chronic Fatigue Syndrome is one million, and we are concerned that this disorder seems to be on the increase. If one-half of the affected patients would otherwise be employed full-time but for their illness, the costs to the economy in lost wages and salary alone likely exceed $10 billion per year.

The demography of CFS shows an excessive risk for persons in their twenties, thirties, and forties. Members of this group are typically in their peak productive years. If several decades of income production are lost to each CFS patient in this group, the economic costs in lost lifetime wages and salary alone would be expected to reach several hundred billion dollars.

The variety of economic costs of this disease also include lost tax receipts, bankruptcies, and dramatically increased health care and disability costs.

Patients typically report becoming sick, followed quickly by being fired from work or forced to resign. Frequently there then remains no health or disability insurance coverage at a time of great medical expense.

It is clear that modest expenditures in increased biomedical research into CFS will be rewarded in decreased costs of this disease to the economy.

In recent years a number of agents, as well as some genetic predisposition, have been suggested within the research community as possibly being involved in some way in the Chronic Fatigue Syndrome. Most of the agents proposed are viral, and immune dysregulation is thought to be central in the Chronic Fatigue Syndrome. We have treated a number of patients with CFS with transfer factor (TF) therapy, a technique for providing adoptive transfer of cell-mediated immunity. This therapy has shown clinical efficiency in a number of diseases believed to be of viral etiology, or cause, but for which the causative agent has not yet been identified, and also in a number of disorders of immune dysregulation.

The small Federal biomedical research effort on Chronic Fatigue Syndrome has been welcome, but should be dramatically increased. The National Institute of Allergy and Infectious Diseases has a small intramural program involving CFS, but currently funds little extramural research directly related to CFS.

We make recommendations to the Congress to improve activities of the National Institutes of Health related to Chronic Fatigue Syndrome, as follows:

(1) To increase biomedical research into CFS, the National Institutes of Health should be directed to designate a senior official within the Office of the Director to coordinate NIH activities concerning CFS, to report to Congress on an annual basis about CFS activities, to use a variety of CFS grants solicitations types, and to designate a regional center for CFS research in the areas of greatest concentration of CFS. The NIH

should be urged to conduct CFS research in all institutes involved in AIDS research, and, to increase utilization of the wide range of CFS research performed in other countries, use the facilities of the Fogarty International Center for CFS research.

III To continue and expand its research on CFS, the National Institute of Allergy and Infectious Diseases should be directed to expand its extramural activities to areas of greatest concentration of CFS and should be earmarked $10,000,000. The NIAID should be strongly urged to cooperate with the National Cancer Institute in basic CFS research; to develop specific assays, a reagent bank, gene sequencing techniques, and model clinical care protocols related to CFS; to conduct CFS symposia; to facilitate data exchange among CFS researchers; to develop state and community-based CFS clinical research opportunities; and to fund at least 50% of approved CFS research grant applications.

Thank you for the opportunity to provide testimony on this important health issue to the Committee.

STATEMENT OF C. RICHARD CONTI, M.D., AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology is a 17,200 member non-profit professional medical society and teaching institution whose mission is to foster optimal cardiovascular care and disease prevention. In keeping with our mission, the College confirms our strong and ongoing support for quality medical research in the areas of prevention, diagnosis and treatment of cardiovascular disease.

The National Heart, Lung, and Blood Institute (NHLBI) is critical in sustaining that effort; therefore, we urge the Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to commit funding at the highest reasonable level to the Institute.

The NHLBI estimates that at least 58 million Americans suffer from heart disease, and of these, approximately 40 million are under 65 years of age. Almost half of all deaths in this country may be attributed to cardiovascular diseases, with the economic cost to the nation reaching $127 billion annually, half due to health expenditures and half for lost productivity.

Yet, because of fiscal constraint, three quarters of all approved research projects within the Institute go unfunded. The Administration's budget request for FY 1990 for NHLBI is $1.082 billion, an increase of 3.4% over FY 1989. We applaud the fact that the Administration has recognized the importance of this investment and has requested an increase for the NHLBI while many domestic programs are being cut to reduce the budget deficit. But such a modest increase will not even permit the Institute to sustain its current programs.

Consequently, the American College of Cardiology joins our colleagues in the medical research community in calling for a FY 1990 appropriation level of $1.239 billion for the NHLBI.

While the College is concerned with every facet of the Institute and the patient community the NHLBI serves, in this testimony we would like to stress two specific issues: 1) Research Project Grants and 2) supporting the next generation of medical researchers.

Research Project Grants

The Research Project Grant remains the cornerstone of the National Institutes of Health's effort to advance our knowledge of the cause and cure of disease. Regrettably, the NHLBI continues to experience a dramatic decline in competing Research Project Grants, which have dropped from 966 in 1987 to 851 in 1988 and to an estimated 646 in 1989. The Administration's budget for next year will fund only 601 competing research projects.

We think Congress should allocate $805 million for Research Project Grants. This would allow full funding of non-competing grants and would award approximately 900 new competing grants. This is still below the 1987 level, but closer to the level of one-third of approved competing grants which we consider a reasonable minimum.

Supporting the Next Generation of Medical Researchers

Our recent survey of cardiology training directors revealed that 80% of the directors believe that additional researchers are needed in our field. The NHLBI has had a longstanding commitment to encouraging research careers and providing training through two programs:

Research Career Development Awards are crucial to the mission of the NHLBI because they assure an adequate supply of well-trained researchers and keep the Institute on the cutting edge of technology. At a minimum, Congress should grant an additional $2 million above the Administration's request to fund 437 career awards.

National Research Service Awards fund much of the training of our future medical researchers. This vital effort should receive an additional $3.3 million to provide an increase of 119 positions to a level of 1,600 awards.

Other NHLBI Programs

While the ACC has stressed the Research Project Grants and training components of the NHLBI in this testimony, we recognize and support adequate funding for the other research and education efforts of the Institute. Specialized Centers of Research, Research and Development Contracts, Intramural Research, Other Research, and Research Management and Support are all critical to the mission of the Institute. The chart on the final page of this testimony provides details on our specific budget proposals for all these programs.

Conclusion

In summary, the American College of Cardiology would like to stress the critical priority of cardiovascular research, since cardiovascular disease is the major cause of death in the United States, with tremendous personal and economic loss to our country. The programs of the NHLBI have been instrumental in achieving proven reductions in heart attacks and mortality from cardiovascular disease, but so much more needs to be done. Keeping our nation at the forefront of research will obviously require adequate resources.

We wish to thank the members of the Subcommittee for your consistent support of the NHLBI in the past and for your help with our future efforts to restrain the nation's number one killer - heart disease.

American College of Cardiology
Proposed FY 1990 Budget
National Heart, Lung, and Blood Institute
(Includes AIDS)
(Amounts in Thousands)

Research Grants	No.	Amount
Research Project Grants:		
Noncompeting projects	2,201	$559,188
Admin. supplementals	(60)	1,976
Competing projects	900	243,066
Subtotal, res. projects	3,161	804,230
Research Centers:		
Specialized centers	66	103,876
Other Research:		
Research career programs	437	29,394
Coop. clinical research	14	2,776
Minority biomed. support	0	2,452
Other research related	112	7,520
Subtotal, other research	563	42,142
Total, research grants	3,790	950,248
Training		
Individual Awards	225	6,489
Institutional awards	1,375	38,001
Total, Training	1,600	44,490
R & D Contracts	242	107,655
	FTEs	
Intramural Research	423	85,287
Research Mgt. and Support	426	51,320
Total, NHLBI FTEs	849	$1,239,000
Awards & Contracts	5,632	

STATEMENT OF MARVIN I. DUNN, M.D., THE AMERICAN COLLEGE OF CHEST PHYSICIANS

I am Dr. Marvin I. Dunn, President of the American College of Chest Physicians. I am also the Franklin E. Murphy Professor of Medicine and the Director of Cardiovascular Laboratories at the University of Kansas Medical Center in Kansas City, Kansas.

I would like to begin by thanking you for affording me the opportunity to submit this testimony for the record on behalf of the American College of Chest Physicians. ACCP is a professional medical specialty society of more than 14,000 physicians, scientists and educators who specialize in diseases of the heart, lungs and circulatory system. The College appreciates this opportunity to offer its views to this Committee on Fiscal Year 1990 appropriations for the National Heart, Lung and Blood Institute (NHLBI), and the pulmonary activities of the National Institute of Allergy and Infectious Diseases (NIAID).

I would like to preface this statement by emphasizing that ACCP enthusiastically supports the activities of the National Institutes of Health, particularly those of NHLBI and NIAID. We unequivocally support NIH's commitment to support the entire spectrum of research, both basic and applied; both for treatment and prevention.

With respect to funding levels, ACCP believes that in order for NHLBI to be able to fulfill its mandate and provide the leadership which is crucial to our national biomedical research effort, an NHLBI appropriation of $1.239 billion is necessary for Fiscal Year 1990. Likewise, given the importance of NIAID's research efforts related to viruses, and its study of such diseases as pneumonia and menigitis, ACCP strongly supports increased non-AIDS research funding for NIAID, to a level of $630,495,000 in Fiscal Year 1990.

In total the College wishes to express its support for an appropriation level of $8.416 billion for Fiscal Year 1990 for the National Institutes of Health (NIH). This recommended level of funding would be consistent with our national commitment to biomedical research and would translate into an appropriate, sound, and progressive level of NIH research activity which accurately reflects its vital mandate.

Turning to the excellent work of NHLBI, under the very able leadership of Dr. Claude Lenfant, tremendous strides continue to be made in combatting cardiovascular and cardiopulmonary diseases. ACCP's recommendations are aimed at maintaining that momentum. Although we recognize the strains that have been placed on the federal budget in recent years, the fact that diseases of the heart and lungs continue to pose the most serious threat to our Nation's health must not escape us. The desirability of exercising fiscal austerity should not cause us to lose sight of this fact.

According to NIH, cardiovascular diseases afflict more than 70 million people. In 1986, 979,000 deaths or roughly fifty percent of all deaths were attributed to cardiovascular diseases. The prevelence of arteriosclerotic-related cases is reflected in an examination of the deaths by diagnosis: coronary heart disease, 524,000 deaths; stroke, 148,000 deaths; and peripheral vascular disease, 44,000 deaths. Other cardiovascular diseases such as hypertension led to 263,000 additional deaths.

Some million persons have been diagnosed as having hypertension, or heart/circulatory disease. In 1985, 21 million persons had some form of heart disease; 6.7 million with coronary heart disease, 1.5 million with rheumatic heart disease, 12 million with other forms of heart and vascular disease. More than 2.7 million persons were estimated to have cerebrovascular disease.

In addition to the untold costs of human suffering, cardiovascular diseases are responsible for a loss of well over one hundred billion dollars each year in productivity, wages and costs of medical care. The most telling statistic, however, is that cardiovascular diseases continue to be the number one cause of death in this country. Indeed, if one adds lung and blood diseases to the tally, the stark reality is that 1,159,000 deaths in 1986 or over fifty-five percent of all deaths fall within the disease categories that it is the mission of NHLBI to combat. These diseases represent five of the ten leading causes of death. And yet despite this fact, NHLBI's allocation among the NIH institutes amounts only to approximately fifteen percent.

Two points need particular emphasis. First, while the efforts of NHLBI have helped lead to a significant decline in the death rate from cardiovascular diseases over the past twenty years, the incidence of these diseases and their costs, in terms of human suffering, death, and economic loss remains staggering. Second, when one views the progress made to date and takes into account the costs that would have been incurred had it not been for the work of NHLBI, the conclusion is clear: monies spent to combat these diseases have been monies well spent. Indeed, I believe it fair to say that for every dollar spent by

NHLBI, the return in terms of dollars not spent on health care, etc. exceeds most other expenditures by the federal government.

It is therefore that NHLBI be afforded sufficient resources to continue its efforts to combat the full array of cardiovascular diseases: hypertension, cereberal vascular disease, coronary heart disease, arrhythmias, heart failure and shock, congenital and rheumatic heart diseases, cardiomypathies and heart and circulatory system-infection. Although the NHLBI has made considerable progress in the cardiovascular area, the battle against these diseases is far from over.

NHLBI's commitment to the study of diseases of the heart and lung is evidenced most clearly in its integrally-linked chain of research methodologies. Comprised of basic research, applied research, clinical investigation and demonstration/health care delivery programs, this system demonstrates the tangible advances which have been made available to the American public through the sponsorship of NHLBI.

The National Institute of Allergy and Infectious Diseases, NIAID, sponsors important research projects which have broad implications in the respiratory field. Studies involving influenza viruses, and respiratory syncytial and parainfluenza viruses, provide important additions to our current level of knowledge of degenerative chronic diseases. Therefore, the funding level for NIAID should be increased as detailed at the outset.

Today, the ACCP continues to lend its support to those research efforts which are aimed at the ultimate approach to cost-saving -- prevention. NIH appropriation levels must be increased to insure that our progress toward that goal is not thwarted. The Federal Government must not turn its back on biomedical advances of the future which could yield billions of dollars in health care savings. Funding levels consistent with the important goals and essential mandate of NIH must be achieved. On behalf of ACCP's membership, I would like to thank you for affording us this opportunity to present its views.

STATEMENT OF DANIEL PERRY, EXECUTIVE DIRECTOR, ALLIANCE FOR AGING RESEARCH

Mr. Chairman and distinguished members of this Subcommittee, it is my pleasure to be able to outline to you the concerns of the Alliance for Aging Research regarding the direction of research conducted at the National Institutes of Health to improve the health and independence of older Americans.

Earlier this year, the Alliance for Aging Research, together with a coalition of 20 of the nation's most prominent health care organizations led by former Health, Education and Welfare Secretary Joseph A. Califano, Jr., announced Project Independence for Older Americans. A cornerstone of this effort is to focus research attention and resources to attack the real problems of aging -- problems like immobility, memory loss and incontinence -- that too often rob older people of their personal independence.

We need a major national effort -- on the scale and intensity of the Apollo Space Project -- to shrink the period of time during which the elderly must depend on the help of others. This year, although the health care of the elderly will top $180 billion, the National Institutes of Health will spend only $389 million on research related to human aging -- two-tenths of one percent of the medical costs. If you look at aging research institute by institute, you will notice that the three research institutes with the greatest focus on the conditions of aging -- the National Institute on Aging, the National Institute on Arthritis and the

National Institute on Deafness -- are the three lowest funded NIH institutes.

Project Independence for Older Americans is an effort to put research in human aging where it belongs -- on a par with cancer, AIDS, and heart research. Project Independence is the most cost effective investment Congress can make. Each one-month reduction of dependency for our citizens over age 65 means savings of up to $4 billion in health care and custodial costs.

More Americans are living longer, and as they do, the period of time increases during which they need help in the tasks of daily living, tasks such as bathing, dressing, eating and toileting. The cost of providing help to today's elderly is mind-numbing. As the baby boom becomes the senior boom early in the next century, the cost of confronting this dependence will become astronomical. If current rates of nursing home use continue, we will need 600,000 new nursing home beds by the year 2000, at construction costs approaching $20 billion.

Such an effort to achieve independence for older Americans has substantial public support. In April, the Alliance for Aging Research released the results of a poll conducted by the firm of Penn + Schoen showing that three out of four Americans favor a major government research project -- on the scale and intensity of the effort we made to put a man on the moon -- to reduce the period of time during which the elderly must rely on the help of others. Americans also gave us a very clear direction in terms of just how strongly they favor research spending in human aging. Fifty-nine percent of Americans say health care research spending should be increased now as a way to reduce future health care costs, despite the pressures of the current deficit. Sixty-one percent favor increasing federal support for aging research over increasing other critical areas of health care research, such as AIDS.

Given the tight fiscal constraints of the fiscal year 1990 budget, we do not expect this subcommittee to raise aging research spending at the National Institutes of Health to the $1 billion level we think is needed. However, this subcommittee take an important step this year to increase the status of aging research and invest in the future health and independence of this nation's 30 million senior citizens.

Basic research has brought us to a new threshold of discovery in human aging providing a promising prognosis for a more independent older America. If, for example, we doubled the $20 million a year we spend on osteoporosis research, the U.S. would be well on its way to controlling this disorder by the year 2010. Currently some 24 million Americans suffer from osteoporosis, costing approximately $10 billion a year. Surgeon General C. Everett Koop recently reported tremendous research progress in curbing incontinence among older people using existing technology. An estimated 800,000 older Americans suffering from incontinence require $10 billion in care each year, mainly in nursing homes.

It is through this type of research supported by this subcommittee that we will be able to achieve independence for our senior citizens. While the current fiscal outlook is tight, we are confident more can be accomplished. Within the last few years, America and this subcommittee has responded to the AIDS crisis. Research into finding a cure for this dreaded disease which claimed the lives of 31,000 Americans last year now totals $1.3 billion. Independence for older Americans is an equal challenge that will help promote the successful aging of our population. It is an investment in the health of a nation where over 12 million older people are in need of hospital or long term care each year.

Mr. Chairman, knowing of the tight fiscal constraints of this subcommittee I have outlined some areas of the budget where a down payment for an investment in independence for older Americans can be made.

First, we must start with training an adequate number of qualified researchers and practitioners in the area of aging and geriatrics. In a report focusing on the dramatic shortage of trained specialists in the field of geriatrics, the Institute of

Medicine recommended the establishment of 10 Geriatric Research and Training Centers. Last year, as part of the Appropriations bill, one of these centers was called for but without any additional funding for its establishment. This year, as a way to move the nation closer to meeting the recommendation of the IOM, we recommend that five centers be established at the approximate cost $7.5 million.

The low level of funding for the National Institute of Aging is a growing concern. The NIA is the lead agency responsible for a broad range of basic, clinical, psychological and social research affecting 30 million Americans today and, with good fortune, eventually every American. Ideally, the Alliance for Aging Research would like to see the NIA budget increased to a point where it is able to fund approximately half of all approved grants and meet the recommendations of the Federal Government's Advisory Panel on Alzheimer's Disease. In fiscal year 1990, that would take approximately $550 million. Short of that level, $394 million for the NIA next fiscal year would help bring the institute more in line with other NIH institutes.

The research of the National Institute of Arthritis and Musculoskeletal and Skin Diseases directly affects the independence of older Americans. More than 37 million Americans suffer from arthritis and related disorders. An estimated 24 million Americans, mostly older women, have the debilitating disorder known as osteoporosis. Yet, the NIAMS is one of the lowest funded institutes at NIH. Consistent with the recommendations of the national task force reviewing this institute, the Alliance for Aging Research recommends increasing its budget to $192 million in the next fiscal year.

Mr. Chairman, your leadership in the establishment of the National Institute of Deafness and Communicative Disorders will do much to improve the lives of older Americans. About half of all hearing and speech impaired people are over the age of 65. By the year 2000, more than 12 million elderly Americans will be affect by some hearing or speech problem. Increasing the funding of our newest institute of health needs to be made a priority. Despite research gains, there is a dramatic shortage of clinical scientists to work on the problems of deafness and hearing disorders. We encourage your efforts to advance the work of this institute and stand willing to help in whatever way we can.

STATEMENT OF GRACE POWERS MONACO, NATIONAL LIAISON CHAIRMAN, CANDLELIGHTERS

My name is Grace Powers Monaco. I am the National Liaison Chairman of the Metropolitan Washington Area Candlelighters. This association serves as the legislative arm of an international volunteer coalition of 300 groups of parents whose children have or have had cancer in 50 states and Puerto Rico, Australia, Brazil, Canada, Chile, Denmark, England, Finland, France, Germany, Greece, Guatemala, Holland, India, Indonesia, Ireland, Israel, Italy, Mexico, New Zealand, Sweden, South Africa, Spain and East Africa.

Candlelighters is well aware of the pressures put upon the Committee to control spending through zero based budgeting. However, this Committee is well aware that constrictions in spending should not be made in areas that directly impact on saving lives and lifetimes. It is inappropriate to barter our children's futures and livelihoods at the expense of cutting back on basic research in cancer and its translation into effective cures and controls through clinical trials.

At the time we began testifying before this Committee in 1970, we were saving -- curing -- less than 15% of our children diagnosed with cancer. When we testified last year we were able to indicate to you that that figure had increased to 65% and today it is better than 67%.

The jump from 15 to 65% was brought about by understanding how to better diagnose, stage and manage our childrens cancers through a more complete understanding of tumor biology and by finetuning the treatments developed from that understanding to maximize their benefit.

Building upon that success NCI's intramural program -- until sidetracked by the need to allocate cancer personnel slots to the AIDS problem which have not been replaced -- were beginning to look at the "hard" remaining issues in pediatric cancers which could expand beyond the current 65-68% cure rate to the next threshhold of 75% or better. Their efforts included:

(a) looking at management of Central Nervous System disorders in pediatric cancer which, if solved could increase the cure rates in some refractory cancers to better than 80%;

(b) devising new methods of management of the infection complications of childhood cancer patients who are immune compromised;

(c) adding to the medical personnel assigned to childhood cancer management to handle the addition of children to clinical trials who want to be included but cannot be because of personnel shortages and which would answer the trial questions more rapidly;

(d) increasing the speed of the unravelling of the molecular biology questions in pediatric tumors including the understanding of the genetic mechanisms involved in tumor cell proliferation and metastasis. It is the unravelling of these questions e.g., the cmyc oncogene in neuroblastoma and the familial patterns in retinoblastoma that will permit earlier detection through surveillance of children at risk thus increasing the opportunity of cure and potentially being able to do direct interventions that will correct the condition causing the cancer;

(e) devising and applying new adjuvant therapies which will increase the ability to more effectively manage and increase the rate of cure in childhood cancers affecting the muscle, kidney and bone and in childhood AML [promising results from VM-26] and refractory testicular cancer [ifosfamide]; and

(f) devising and applying new adjuvant therapies that will decrease the toxicities of existing regimens which will cause less physical disability and minimal learning dysfunctions in our children who are particularly in a high risk class and need to be treated heavily and aggressively to achieve control and cure e.g., WR 2721 use to minimize the toxicity of ionizing radiation.

NCI intramural research program and its internal and external clinical trials programs concerned with pediatric cancers have been asking not only how can we cure or control this particular cancer but also how does the treatment affect patients in their lifetimes. It is the answer to this latter question and the sensitivity of NCI to the need to develop the least restrictive therapies providing the least long term effects that will return to families and the community children with the best opportunity to live long creative and productive lives and contribute to this countries gross annual product.

NCI's communications programs such as the Office of Cancer Communications, the Cancer Information Services and the Physicians Data Query Program both the files devoted to physician needs and those being developed to deal with patient and public information needs that is disseminating the word on the best standard and investigational therapies available and is having an increasing impact on "getting the word out" on the good news of control and cure for most cancers.

None of these programs can function effectively on the funds currently allocated to them under the President's budget.

I remember when I was testifying before you in 1970 you considered that a crisis in funding existed when the percentage of approved grants funded fell below 50%. At that time the crisis was precipitated by a 35% figure. It was this Committees opinion at that time that to go below the 50% figures would cause a slow down both in finding new answers, keeping the momentum of the program up and disseminating information on the "possibilities" in control and cure out to the communities you served.

You were right then and we ask you to apply that same wisdom now.

Today under the President's budget we will be funding 29% of the approved grants. The Bypass budget will only bring this amount up to 35%. For this reason although we certainly urge you to accept the bypass budget recommendations on personnel slots and funding levels, we would also ask you to increase the allocation an additional 100 million including AIDS to 2.3 overall allocation to get research grant funding up to the 50% approval level which would put it beyond the point this Committee had recognized as a "crisis" level.

Candlelighters is also very concerned about the current salary level for our NCI pediatric oncologists. The recent Department of Defense initiative to provide additional compensation for Public Health Service Medical Officers without explanation excluded pediatricians.

It speaks ill of our commitment to our children, our future, to leave the pediatrician community out of the bonus structure. Many of these physicians faced with having to live in a highly priced housing market and getting ready to send their children away to college are hard pressed to stay where they wish to stay -- advancing the cause of medical research on the federal level. This blow will make it even more difficult from financial and morale reasons for them to remain where they wish to be.

The pediatric cancer and AIDS programs of the National Institute of Health Clinical Center supported by the intramural research program are looked to by pediatricians and researchers all over the country as establishing a benchmark against which their care is measured. As a country we cannot afford to erode the good opinion we have earned and the progress that has been forthcoming from these fine and dedicated researchers.

Mr. Chairman, Members of the Committee, on behalf of all parents of children with

STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE SOCIETY OF GYNECOLOGIC ONCOLOGISTS

The Society of Gynecologic Oncologists, an organization of all the certified specialists in gynecological cancer, and the American College of Obstetricians and Gynecologists, representing of more than 28,000 physicians specializing in the delivery of health care to women, are strongly concerned that without adequate funding for the National Cancer Institute (NCI), the development of vitally needed new treatments for women who develop gynecologic cancer will be compromised. To remedy this situation we urge you to support adequate funding for the NCI. Such funding is crucial to meet fully the challenges and opportunities in cancer research.

Although there have been many achievements in cancer research, each and every day 1350 Americans die of cancer. For those cancer patients, we are too late. But for others, cancer research and treatment may mean the difference between life and death.

It is estimated that we have learned more about cancer during the past 15 years than we did in the preceding 100 years! Advances in molecular biology now allow us to probe the inner workings of the malignant cell. Studies impossible 10 years ago, are now routinely done by research fellows in their early training. NCI grants have contributed greatly to these breakthroughs. This year because of an inadequate budget, only 25-30% of the cancer research grants found by peer review to be scientifically meritious will receive support. The NCI professional judgment budget would increase that number to approximately 50% of the number approved.

Cancer centers supported by the NCI are a network of medical centers that quickly bring the latest advances in cancer research to the women and men of the United States - what could be more important to all Americans, when one out of four will develop cancer in their lifetime? Yet, this year, 3-5 of the 60 cancer centers currently funded by the NCI may no longer be supported and 3-5 more may go unfunded next year, unless adequate funding is made available.

As specialists in women's health care and more specifically women's cancer, we are also concerned about funding for clinical treatment research. Clinical trials are carried out in cancer centers, clinical cooperative groups, and community oncology groups across the country. It is through these NCI-supported centers and groups that new approaches to cancer treatment are brought from the laboratory directly to the patient. A major effort to expand clinical trials is in progress. The increased number of patients enrolled in these studies will speed information about new therapies and at the same time ensure that more patients will receive state-of-the-art treatment or therapy thought to be most effective. Inadequate funding could seriously undermine this important effort.

Clear examples of such accomplishments include the reduction in death from cervical carcinoma by the discovery of the Papanicolou Test for screening and the international staging and reporting of treatment methods. As progress has been made, the questions have become more sophisticated and now require carefully designed prospective studies to reach valid answers. In the absence of such scientific study, physicians are forced to rely upon any available data such as uncontrolled retrospective analysis or anecdotal reports both of which carry high risk for error. Without reliable data, treatment methods that are ineffectual can be perpetuated and costly as they waste resources and lives and delay progress in improving outcome.

One of the NCI study groups, the Gynecological Oncology Group, which focuses solely on cancer in women, has produced exciting advances in cancer treatment. Another example of the significant contributions made by NCI is in the treatment of cancer of the external female organs. Prior to its studies, women with advanced cancer of the vulva were commonly subjected to radical surgical removal of pelvic lymph nodes which significantly increased the risk of treatment. As a result of studies by the Gynecologic Oncology Group it has been shown that such surgery is rarely indicated and the use of adjunctive radiation therapy is of value in treating these areas with the additional benefit of reducing local recurrences. These findings have dramatically shortened the length of hospitalization for these patients, reduced the incidence of subsequent hospitalizations, and increased the overall cure rate.

Cancer of the uterus affects more than 35,000 women each year, most of whom are over 60 years of age. Because of the cooperative studies of the Gynecologic Oncology Group, favorable prognostic features have been identified that exempt certain victims of this disease from the necessity of adjunctive radiation therapy. In fact one-third, more than 11,000 of these women, are spared additional radiation therapy and its potential complications. The reduction in human suffering and annual cost savings are substantial. Cancer of the ovary now kills 1 of every 70 American women. Decades of effort by isolated institutions resulted in little or no change in the death rate from this disease. However, NCI studies have now defined the optimal treatment for the early stages and significantly improved the treatment of the advanced stages of this malignancy. Improvement in cure rates will only come from a continuation of the NCI studies that have been initiated and under funding might bring them to a close.

The NCI also serves as a forum to bring together groups concerned with various aspects of cancer. Last December, the NCI hosted a meeting with representatives from the American College of Obstetricians and Gynecologists, the College of American Pathologists, Planned Parenthood and a number of other organizations, to discuss the differing terminology used when reporting Pap smear results from the laboratory to the physician. A standardized nomenclature for reporting Pap smear interpretations resulted from this important NCI conference.

Without adequate funding for NCI, the sophisticated questions related to cancer and women cannot be answered as they require the scientific design, the prospective planning, and the aggregation of patient data from multiple institutions. Without accurate and dependable data, ineffectual treatment methods can prevail that are both wasteful and harmful. Continued support for NCI will result in improved outcome and reduced cost as ineffectual treatment methods are replaced by effective methods, length of hospitalization shortened and readmission for recurrences reduced.

The understanding of cancer and our ability to cure can only come through research, which we believe may produce some of the most exciting scientific advances in the history of biomedical research. If NCI is not given adequate resources to continue our momentum it would clearly be a tragedy for the cancer patient. We owe a sustained commitment to the 506,000 Americans, including 236,000 women, who face death from cancer each year.

STATEMENT OF THE ASSOCIATION OF PROFESSORS OF MEDICINE

The Association of Professors of Medicine (APM) is pleased to have the opportunity to submit its views on the FY 1990 appropriation for the National Institutes of Health (NIH), and the health professions training grants program administered by the Health Resources and Services Administration (HRSA).

Representing the Chairmen of the departments of medicine at the 127 U.S. medical schools, the APM as an organization regards funding for the research and research training efforts of the NIH as one of its highest public policy priorities. This level of importance attached to the NIH is rooted in the fact that all APM members are physician scientists, as well as that together departments of medicine received almost $1 billion in FY 1988 in extramural funding from the NIH (representing one third of total amount of extramural awards) and 35 percent of all research training grants. Thus, it is clear why departments of medicine, and their chairmen and faculty, should and do place such importance on the annual appropriations for the NIH.

Turning to the upcoming fiscal year appropriation, the APM has historically been very supportive of the recommendations of the Ad Hoc Group for Medical Research Funding and is so again for the FY 1990 appropriations cycle. This coalition is well-known to members of the subcommittee, so there is no need to dwell on the high quality of its work. While the Association does urge the Subcommittee to adopt the recommendations of the Ad Hoc Group for FY 1990, we also wish to make the following additional comments.

First and foremost, the APM wishes to express our dissatisfaction with the budget request for the NIH submitted to Congress by the Bush Administration. When funding for AIDS is removed from the Administration recommendation, the overall increase for the NIH is only 3.6 percent -- well below the biomedical research and development price index for the current fiscal year. While the APM applauds the Administration's decision to call for a substantial increase in NIH AIDS funding, we reject the notion that this should hold back the advancement of non-AIDS portions of the budget. The Association is also opposed to the arbitrary request by the Administration for a ten percent cut in the amount of funding for each research grant. This is known euphemistically as a "downward negotiation"; make no mistake, it is a cut in funding from the level determined by the peer review process, with no negotiation involved. Additionally, APM is distressed by the Administration's plans to phase out the Biomedical Research Support Grant program, and to cap annual investigator salaries at $120,000. The former has been an important source of funding for our research enterprise, and especially in support of new investigators. The latter, APM believes, is an unwelcome development and runs counter to the long-standing NIH policy of first and foremost attracting the most qualified and highly trained scientists to research.

The last area of the Administration budget proposal upon which we would like to comment is funding for research training grants. Under the Bush plan, the number of these grants would be increased in FY 1990 by 178, to 10,484. While APM is pleased that the Administration is recognizing the critical role that institutional training grants and individual training awards play in attracting and supporting young investigators to careers in research -- a crucial development if the scientific advances of the last 40 years are to continue -- we are nevertheless distressed that the number would still fall below the FY 1988 level. As noted previously, departments of medicine received a major share of this type of award in FY 1988, as well as in previous years. The importance of these training funds are evidenced by the also previously noted overall level of extramural grant funds going to departments of medicine (almost $1 billion in FY 1988). The Association doubts seriously that without the early research training support to attract qualified young physicians to research careers, that departments of medicine would have been able to submit as many proposals judged to be deserving of the large amount of support they have received.

Before laying out our specific recommendations for FY 1990, we want to make the following general observations about the current situation at the NIH. The first is that as scientific methods become more sophisticated and equipment and personnel more highly specializied, the cost of the medical research effort increases significantly. The NIH itself estimates that in the last few years to simply continue the same level of effort from one fiscal year to the next requires increases averaging 13 to 15 percent.

A second observation concerns the amount of time funds are committed for individual grants, which for more than half of the grants awarded in FY 1988 was five years. This is in contrast to 1984-85, when less than one fifth of all grants were awarded for this length of time. While it is important for investigators to have time to carry out their work before having to reapply for funding, the ultimate result of this lengthening of commitments is less funds available for new and competing awards. In the current fiscal year, most of the available extramural funding will go to support noncompeting awards, as well as increases in NIH AIDS activities. APM fears that a continuation of this pattern will stifle the funding of important emerging areas of scientific investigation -- always one of the hallmarks of our national research enterprise.

Specifically, for FY 1990 the APM recommends an overall NIH appropriation of $8.416 billion, a 5.7 increase over the current service level of $7.958 billion. This recommended funding level should allow for the restoration in FY 1990 of the average ten percent "downward negotiation" that has taken place on most grants for FY 1989. The Association believes it is important to fully fund the existing research program before embarking on any campaign of rapid growth. At the same time, we believe the NIH must be provided with funding allowing it to maintain some measure of growth, in order to provide support for young investigators and emerging areas of investigation.

The APM's recommendation also assumes funding for approximately 11,800 research training grants, an increase of five percent over the FY 1988 level, as well as funding for the modest stipend increase initiated by the NIH last year. As previously mentioned, training grants and awards are particularly important to attracting young physicians to careers in research. Last year's rise in the average stipend level will certainly assist in this effort by narrowing the gap in income between a research career and one in clinical or private practice. We urge only that the stipend increase not come at the expense of the total number of training grants and awards.

Turning to the HRSA health professions training, the APM urges the Subcommittee to provide an appropriation for the general internal medicine and pediatrics program of $23 million for FY 1990, the full amount authorized in last year's health professions reauthorization act. There is clear evidence that there is a continuing shortage of general internists and other primary care physicians; these funds -- which support not only residency training but fellowships for physicians who plan to teach general internal medicine -- are an important step in alleviating this shortage.

The APM thanks you for this opportunity to submit our views. We would be happy to assist the Subcommittee in any further way in this matter. Please call Mr. Jim Terwilliger, APM's Director of Government Relations, at (202) 857-1158 should you have any questions.

STATEMENT OF EDWARD S. HORTON, M.D., CHAIRMAN, NATIONAL DIABETES ADVISORY BOARD

The National Diabetes Advisory Board (NDAB) was established by Congress to report to Congress and the Secretary of Health and Human Services on recommendations for future policies, programs, and budgetary requirements related to Federal diabetes research and health care activities. A copy of our annual report is enclosed.

Diabetes mellitus afflicts an estimated 11 million people in the United States and can result in life-threatening complications that affect the eyes, kidneys, cardiovascular system, and nervous system. In fact, virtually every major organ system in the body is damaged by diabetes. Therefore, the true human cost of diabetes must include blindness, renal failure, amputation of extremities, loss of nerve sensation, babies born with birth defects, strokes, and premature heart disease. Following are several examples of these costs:

- Diabetes accounts for approximately 30 percent of new cases of end-stage renal disease in the United States. Within the next decade, diabetes-related kidney disease will account for more than one-half of all enrollees in the End-Stage Renal Disease Program.
- Diabetes is the leading cause of new blindness in adults; approximately 5,800 people become blind each year from diabetes;
- An estimated 50 percent of all nontraumatic amputations in the United States occur in people with diabetes.
- Heart disease is twice as common and more often fatal in people with diabetes than in the general population.
- Approximately 50 percent of people with diabetes have hypertension compared with about 20 percent of persons without diabetes; therefore, diabetes increases the risk for heart disease and cerebrovascular disease.
- Babies born to women with diabetes have a threefold increase in the frequency of birth defects, a 5-fold increase in other complications that require intensive medical care in the early days of life, and a higher mortality rate than babies born to women without diabetes.
- Detectable loss of nerve function occurs in approximately 40 percent of persons with diabetes; after 25 years of disease, more than 90 percent are affected.
- People with diabetes are more than twice as likely as those without diabetes to require hospitalization during the year; for children, the rate is 5.3 times greater.

Bleak as these statistics are, they represent a vast improvement over the situation that existed just a little more than a decade ago. In those days, proliferative retinopathy and other diabetic eye complications inevitably led to blindness or severely impaired vision. Today, laser treatment and vitrectomy are available to treat these disorders. A decade ago, people with end-stage renal disease and diabetes were not considered to be acceptable candidates for lifesaving kidney transplants or chronic dialysis programs. Today, the presence of diabetes is no longer considered an impediment to undergoing a kidney transplant. In the early 1970's, the chances for a woman with diabetes to complete a successful pregnancy were considered slim. Now, thanks to a combination of research and improved technology, diabetes specialists are able to guide a majority of diabetic women through successful pregnancies. In the past, diabetes patients could only attempt to control their blood glucose levels through indirect and often inaccurate urine tests. Today, devices for direct self-monitoring of blood glucose enable patients to obtain accurate and timely readouts of their blood glucose levels. Through immunology and genetics, we have come closer to understanding the biological mechanisms involved in the genesis of insulin-dependent diabetes mellitus and can look forward to preventing this disease in the future. Major advances in whole or segmental pancreatic transplantation and in the implantation of the insulin-producing beta cells of the pancreas also allow us to look forward to a cure for this disease. In the meantime, considerable advances have been made toward the goal of small implantable devices that monitor blood glucose levels and deliver the corresponding amount of insulin automatically.

However, diabetes continues to be a tremendous economic burden for this Nation, and a major portion of this burden is paid by Medicare, Medicaid, the Public Health Service, the Veterans Administration, and other Federal health care programs. Therefore, combating this disease must be a national priority. Federal funds spent on diabetes activities today can prevent greater Federal spending for patient care in future years.

The Board recognizes the economic constraints facing Congress and the Administration; however, biomedical research and the implementation of research findings are not only vital to the solution of serious health problems facing our Nation but are also extremely cost-effective. We must continue to strongly support these activities, especially at this critical time when we are close to achieving our goals.

BUDGET RECOMMENDATIONS

National Institutes of Health

The Board is concerned that the ability of the National Institutes of Health (NIH) to support research and research training programs has eroded to a critical level. For example, the percentage of approved individual research project grants that can be awarded by NIH has declined by more than 50 percent, from approximately one in two applications a decade ago to fewer than one in four at present. As a result, highly meritorious research programs are being terminated, and young investigators are being discouraged from entering research careers. Because the success of the national diabetes research program depends on advances in basic science and in diabetes-related research projects supported by most NIH Institutes, additional funds must be provided to each Institute.

THE CONGRESSIONAL APPROPRIATION FOR RESEARCH PROJECT GRANTS AT NIH SHOULD BE INCREASED IN FY 1990 TO PROVIDE FUNDING FOR 40 PERCENT OF APPROVED INDIVIDUAL RESEARCH GRANT APPLICATIONS IN EACH INSTITUTE.

National Institute of Diabetes and Digestive and Kidney Diseases

THE CONGRESSIONAL APPROPRIATION FOR NIDDK SHOULD BE INCREASED TO $710 MILLION IN FY 1990.

An appropriation of $710 million would enable the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to:

- Fund 40 percent of approved individual research grants.
- Support the Institute's current research centers at recommended levels.
- Initiate the Diabetes Interdisciplinary Research Centers recommended in The National Long-Range Plan to Combat Diabetes, 1987.
- Provide funds for the new training stipend levels approved in FY 1989.
- Restore the diabetes-related research training and career development programs to the number of positions funded in FY 1980.

I would like to add a few comments in support of the Board's recommendation for the proposed Diabetes Interdisciplinary Research Centers.

Diabetes Interdisciplinary Research Centers

Recent developments in basic science research methodologies and biotechnology have revolutionized approaches to biomedical research. Although many of these developments are applicable to diabetes and its complications, few investigators trained in these disciplines currently apply their expertise to diabetes research. Diabetes Interdisciplinary Research Centers will provide direct support for diabetes-related research in basic science laboratories and thereby encourage, in a cost-effective manner, existing facilities at the forefront of biotechnology to attack specific research questions of importance to the diabetes field.

THE BOARD'S RECOMMENDED BUDGET FOR FY 1990 INCLUDES FUNDS TO IMPLEMENT THESE CENTERS.

Centers for Disease Control

The diabetes program at the Centers for Disease Control is designed to reduce unnecessary diabetes morbidity and mortality by facilitating the widespread application of diabetes research results. This program is an essential component of the national long-range plan for diabetes.

THE CONGRESSIONAL APPROPRIATION FOR CDC SHOULD BE INCREASED BY $5 MILLION IN FY 1990 TO SUPPORT CONTINUED DEVELOPMENT OF THE DIABETES TRANSLATION CENTER AT CDC.

THE BOARD ALSO RECOMMENDS THAT CONGRESS CONTINUE THE STATE DIABETES GRANT PROGRAM AS A CATEGORICAL PROGRAM. THIS PROGRAM SHOULD NOT BE INCORPORATED INTO THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT.

STATEMENT OF ROBERT M. GLICKMAN, M.D., DEPUTY CHAIRMAN, NATIONAL DIGESTIVE DISEASES ADVISORY BOARD

I am Dr. Robert M. Glickman, Chairman, Department of Medicine, College of Physicians and Surgeons, Columbia University, Deputy Chairman of the National Digestive Diseases Advisory Board and President of the American Gastroenterological Association.

Recognition of the serious impact of digestive diseases led Congress to establish the National Commission on Digestive Diseases in 1977 to prepare a national long-range plan for reducing the social and economic burden of these diseases. The Board was established by Congress in 1980 to monitor the implementation of the national plan and periodically update it.

The wide spectrum of disorders known collectively as digestive diseases are grouped together because they all affect the gastrointestinal system, which includes the esophagus, stomach, small and large intestines, anorectum, liver, biliary tract, and pancreas. These diseases are responsible for almost 13 percent of all admissions to general hospitals in the United States and for 10 percent of all surgical procedures. They cost the Nation $50 billion annually, of which $17 billion are direct medical costs, and they affect more than one-half of the U.S. population at some time during their lives. Digestive diseases rank second among all causes of disability due to illness in the United States. Approximately 150,000 deaths annually are caused by these diseases.

In 1979, after the Commission's report was completed, Congress provided additional funds for the digestive diseases program of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). However, analysis of the subsequent appropriations for NIDDK indicates that this momentum was not sustained in the succeeding years. When measured in constant dollars, the total funding for digestive diseases research is essentially unchanged over the past 10 years.

This fiscal trend has had serious consequences. For example, the percentage of approved applications for individual research projects that can be funded by NIDDK has declined from approximately 45 percent in 1979 to 23 percent in the proposed budget for FY 1990. These funding levels cause outstanding research programs to be terminated and discourage young investigators from initiating new projects.

Numerous opportunities now exist to apply recent advances in basic science to digestive diseases research. Such research is a cost-effective investment that must be expanded to reduce future social and economic costs of these diseases. Therefore, the appropriations for NIDDK, the lead Federal agency for digestive diseases research, must be increased.

THE BOARD RECOMMENDS THAT THE TOTAL NIDDK BUDGET BE INCREASED TO $702 MILLION IN FISCAL YEAR 1990.

This budget would enable the Institute to:

- Fund 40 percent of approved individual research grant applications.
- Support the digestive diseases research centers at recommended levels.
- Maintain the number of trainees and fellows supported in FY 1988 by the research training program.
- Initiate a new program of clinical trials in digestive diseases.

Clinical Trials in Digestive Diseases

Carefully controlled clinical trials are an essential component of the research continuum that leads from the laboratory to patient treatment. Without clinical trials, many research questions remain unanswered, and proposed treatments cannot be evaluated.

The Board is concerned that NIDDK has supported few clinical trials in digestive diseases recently due to fiscal constraints. However, information from clinical trials cannot be obtained in any other way. Therefore, the Board has identified representative topics that could effectively be pursued at this time.

- Determination of the efficacy of therapeutic approaches to primary biliary cirrhosis, a disease that affects the small bile ducts within the liver and is a major cause of liver failure.
- Determination of the efficacy of immunosuppressive regimens and newer forms of anti-inflammatory medications for managing inflammatory bowel disease.
- Evaluation of therapies used to treat upper gastrointestinal tract bleeding, a common complication of peptic ulcer disease.
- Determination of gallstone recurrence in patients who were successfully treated with extracorporeal shock wave lithotripsy.
- Examination of the role of the bacterium *Campylobacter pylori* in the development of peptic ulcer disease.
- Evaluation of various agents used to suppress rejection of transplanted livers.
- Determination of the efficacy of *ursodeoxycholic acid*, a naturally occurring bile acid, in treating neonatal liver disease and chronic biliary obstructive disease in adults.
- Quantification of the prevalence of hemochromatosis as an initial step in developing guidelines for early treatment and prevention of this disease, which can damage the liver and other organs.
- Definition of methods for managing irritable bowel syndrome, an extremely common and often disabling disorder characterized by abdominal pain and constipation or diarrhea.

There is also a pressing need for new mechanisms and funds to support the planning and design of these studies. Clinical trials are complex programs that require considerable consultation and collaboration with experts in epidemiology, biostatistics, and clinical trial design. However, most clinical investigators do not have access to the multidisciplinary expertise and related resources necessary to plan and design clinical trials that will have scientifically valid results. The use of planning grants would enable investigators to assemble the expertise required to design complex research undertakings. Additional funds must be provided to NIDDK to support the planning and operation of these trials.

THE BOARD RECOMMENDS THAT CONGRESS PROVIDE AN ADDITIONAL $2 MILLION TO NIDDK IN FY 1990 TO SUPPORT CLINICAL TRIALS IN DIGESTIVE DISEASES.

Several NIH Institutes have personnel assigned exclusively to the support of clinical trials. These individuals coordinate the design and planning of Institute-initiated trials, offer advice to investigators who wish to submit clinical trial applications, and monitor all trials supported by the Institute. Additional staff must be assigned to the Division of Digestive Diseases and Nutrition, NIDDK, to support clinical trials. At a minimum, two additional full-time equivalent (FTE) positions are required for this function in FY 1990.

THE BOARD RECOMMENDS THAT CONGRESS AUTHORIZE TWO ADDITIONAL FTE POSITIONS TO SUPPORT DIGESTIVE DISEASES CLINICAL TRIALS.

Research Training

The availability of trained, independent investigators is particularly critical to future progress against digestive diseases. The Commission recommended in 1979 that NIDDK receive additional funds to strengthen the research training programs. However, the small funding increases provided to NIDDK since 1979 have not kept pace with the costs of inflation. As a result, the number of training grants funded by the Division of Digestive Diseases and Nutrition, NIDDK, has declined from 53 in 1980 to 35 in 1988; postdoctoral fellowships from 47 to 43; and career development awards from 48 to 39 during the same period.

In FY 1989, these training programs incurred an additional major setback that will result in further reductions in the number of research trainees. Trainee stipends for the NIH programs had not been increased in the previous 4 years, despite inflation. These stipends were increased in FY 1989 to keep the training program competitive with other career opportunities for young physicians and scientists. However, additional funds were not provided for this added expense, thus requiring NIDDK to further reduce the number of fellowships and training grants that could be awarded. As a result, the total number of NIDDK trainees will be reduced from 916 in 1988 to 811 in 1989.

It is imperative that Congress provide additional funds to offset the stipend increase.

THE BOARD RECOMMENDS THAT CONGRESS PROVIDE $24.5 MILLION FOR THE NIDDK RESEARCH TRAINING PROGRAM IN FY 1990 TO SUPPORT THE SAME NUMBER OF TRAINEES FUNDED IN FY 1988.

STATEMENT OF STUART A. KLEIT, M.D., CHAIRMAN, NATIONAL KIDNEY AND UROLOGIC DISEASES ADVISORY BOARD

I am Stuart A. Kleit, D.D.S., M.D., associate dean for clinical affairs at the Indiana University School of Medicine and Chairman of the National Kidney and Urologic Diseases Advisory Board. I am pleased to have the opportunity to submit testimony on behalf of the Board to this Committee. I request that my testimony be entered into the record.

The Board was established by Public Law 99-158. Its function as outlined in its charter is to develop a long-range plan to combat kidney and urologic diseases providing specific recommendations for the utilization and organization of national resources in this struggle.

The Board recognizes the enormity of the problems resulting from kidney and urologic diseases and the lack of sufficient funds to combat all these problems. The Board plans to present our complete findings and recommendations in our long-range plan next spring. In the interim, the Board makes the following four recommendations to the Committee:

1. **The Board recommends that Congress provide funds to support research at NIDDK at $667 million, as recommended by the ad hoc group for medical research funding (the NIDDK Coalition).**

2. The Board further recommends that an additional $4 million per year for the next 4 years be appropriated to NIDDK specifically for support of the Modification of Diet in Renal Disease Study.
3. The Board recommends additional funding for research into the causes and cure of benign prostatic hyperplasia.
4. The Board also recommends that the necessary funds be appropriated to the Centers for Disease Control (CDC) to begin the development of a public health initiative in incontinence.

Since last spring, the Board has made considerable progress toward the development of its long-range plan. During the past 12 months, the Board has completed its public hearings held in six sites across the country. The Board has written the first draft of the plan that was distributed to numerous kidney and urologic disease professional and voluntary organizations for comment. The Board is currently revising the document to incorporate changes suggested by the relevant organizations. We plan to share with you the content of the long-range plan as well as our final recommendations next spring.

The first section of the report will deal with the scope and impact of kidney and urologic diseases, including information on the extent, types, and costs associated with these diseases. The difficulty in finding pertinent, reasonably accurate statistical data was more formidable than anticipated. While the extent of end-stage renal disease (ESRD) and its $3 billion cost are evident, the true costs, incidence, and problems associated with more common kidney and urologic diseases are more difficult to obtain. Our current evaluation reveals that direct medical costs for kidney and urologic diseases in 1985 were estimated to be $24.2 billion with indirect costs estimated at an additional $12 billion. This cost is higher than previously estimated and, because of its impact on the elderly, has an out-of-proportion impact on the Medicare budget.

During our information-gathering process, the Board has had an opportunity to learn of several issues that need the immediate attention of Congress. These issues cannot wait until next spring when the Board's recommendations and long-range plan will be completed.

The Board is dismayed to discover that in the current fiscal year the number of research trainees in kidney and urology has been reduced by NIDDK, that research projects are being funded at the 20th percentile, and that funds for the current inadequate number of existing George O'Brien Research Centers will be cut and will be insufficient to allow these centers to operate at levels consistent with study section budget recommendations.

These problems are very serious and disturbing. Not only are we in danger of destroying current research efforts, but these will have grave future ramifications. This situation is a cause for grave concern because we believe that already we are losing potential young investigators to other endeavors. They will not enter the field of biomedical research because of lack of support for training and a rather dismal outlook for obtaining research support from NIH. This could easily lead to the total destruction of our future research potential.

The NIDDK faces an unusual additional problem brought about by a congressionally mandated study to nutritionally prevent or modify the onset of ESRD. Although this study was directed by legislative action, specific funding was not provided. The study, a multicenter clinical trial entitled the Modification of Diet in Renal Disease (MDRD) Study, will attempt to determine whether protein dietary restriction and strict blood pressure control can slow the progression of chronic renal disease. Potentially, the study offers an opportunity to save millions of dollars in treatment costs.

Unfortunately, as currently structured and financed, it is impeding NIDDK's ability to fund research in every area of its responsibility, including diabetes, GI, and hematology research. The problem is particularly acute in the kidney and urologic areas, where it has reduced funding of R01's to the 20th percentile versus the 25th percentile in the other major areas of NIDDK's responsibility. While 25th percentile funding is devastating, funding below that level is destructive.

Progress against kidney and urologic diseases vitally depends on the efforts of trained research personnel. Therefore, training programs must be available for young physicians and other potential research scientists that compensate them on a level comparable with alternative career opportunities. Recognizing the need to boost salaries for researchers, Congress authorized an increase in trainee stipends. Unfortunately, NIH did not receive additional funds to offset the increased stipend costs. As a result, NIDDK had to decrease the number of training grants and fellowships that could be awarded within the current budget. Training funds must be upgraded to return the number of trainees to their previous levels.

In 1985, 30 percent of men older than 40 could anticipate having surgery to correct and alleviate problems associated with an enlarged prostate gland. This disorder is known as benign prostatic hyperplasia (BPH), and its treatment is the second most costly procedure charged to Medicare. In 1985, these charges amounted to 1.4 percent of the total Medicare costs. While there has been a recent consensus development conference on the causes and treatments of BPH, further studies in these areas have been hampered by a lack of research funding for exciting new developments. This situation is further exacerbated by the recent lowering percentile scores for funding of kidney and urology grants at NIDDK. Funding for this area of research at NIH is disproportionately low, given the severe impact BPH has on health care costs in the United States.

During the past year, the Board has been impressed by the data and public hearing testimony concerning the scope and impact of urinary incontinence. This disorder is a psychologically distressing and socially disruptive condition. Primarily experienced by individuals older than 65, urinary incontinence affected 3.3 million individuals in 1985, including more than 50 percent of people residing in nursing homes. According to a 1983 Surgeon General's report, direct and indirect costs for urinary incontinence totaled $8 billion. Despite this enormous impact, urinary incontinence is infrequently discussed, has very little resources devoted to it, and its victims appear to be ignored.

Effective treatment for many forms of incontinence is available; however, very few individuals who are affected (less than one-third) have sought or received medical help for the condition. The Board has met with CDC to explore the possibilities for CDC sponsorship of a pilot project to assess the public health impact of incontinence; to identify gaps in knowledge needed to design effective interventions; to identify target groups for primary, secondary, and tertiary prevention; and to design a demonstration project for implementation.

I wish to close by thanking the Committee for its past and continuing interest in biomedical research into the prevention and treatment of kidney and urologic diseases. In addition, your support of patient care in this arena through Medicare has made it possible for many to continue living who otherwise would have died. This truly has demonstrated that the greatest gift a person can give is the gift of life.

STATEMENT OF WAYNE H. AKESON, M.D., CHAIRMAN, NATIONAL ARTHRITIS ADVISORY BOARD

I am Wayne H. Akeson, M.D., Professor of Surgery, Head, Division of Orthopaedics and Rehabilitation, University of California, San Diego, and Chairman of the National Arthritis Advisory Board.

SCOPE OF THE PROBLEM

More than 37 million Americans--about 1 in 7--have some form of rheumatic disease, and 60 million visit a physician at least once a year for treatment of one or another skin disease.

Arthritis is the second most common chronic illness in the United States, second only to sinusitis, according to the National Center for Health Statistics. Arthritis is the second leading cause of limitation of activity, and more than 100,000 children have some form of arthritis.

Arthritis and related musculoskeletal disorders cost the Nation an estimated $31 billion each year in medical expenditures and associated economic losses. By the year 2000, these disorders will account for more than $95 billion of the Nation's health care costs. Because a large percentage of those with arthritis are 65 years of age and older, much of this burden falls on public resources, such as Medicare and Medicaid.

SUPPORT OF BIOMEDICAL RESEARCH AND RESEARCH MANPOWER

In 1985, Congress established the National Institute of Arthritis and Musculoskeletal and Skin Diseases as a separate Institute and charged it with intensifying and coordinating a national effort to combat arthritis and musculoskeletal and skin diseases. Over the past decade, the cost of doing biomedical research has doubled. Each dollar of funding now supports only half the research it did in 1979. Thus, in real terms, the fiscal year 1990 budget request represents less than a 2 percent increase over fiscal year 1987, the year NIAMS became operational. As a result, NIAMS has not experienced program growth, and opportunities for significant advancement in arthritis and musculoskeletal and skin diseases have been missed.

Almost two-thirds of the NIAMS budget is spent on research grants. Since 1987, the average priority scores for successful grant applications have reflected a steady, impressive improvement in the scientific quality of the applications received. Yet, under the budget request for fiscal year 1990 for NIAMS, the Institute will be able to support only 131 new projects, nearly one-third fewer than the number funded in each of the previous 3 years. Negotiated reductions will continue in the range of 10 to 12 percent. The Board strongly recommends a preferred target award rate of 40 percent, corresponding to a priority score of 170 to 180, and no reductions from budget levels recommended by the peer review groups.

Of particular concern also to the Advisory Board is the lack of progress in replenishing the ranks of researchers, including those in investigative medicine. The budget request represents a reduction of 20 percent in the number of training positions. The Board recommends an expansion of both research training and the critical mechanism of research career awards, the midlevel bridge between postgraduate education and investigative medicine. Manpower development must be continued at the same level as current research, or the ability to undertake future initiatives will be crippled.

There is also general agreement on the need to expand and enhance the NIAMS Intramural Research Program. In particular, the possible establishment of a Laboratory of Connective Tissue Biology within the Intramural Program deserves highlighting. Ongoing construction and renovation on the NIH campus will make available sufficient new space to house such a laboratory, and the Board strongly recommends that NIAMS be provided with additional funds and positions to support this laboratory adequately in terms of personnel and equipment.

PROGRESS IN ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES: SELECTED OPPORTUNITIES FOR FURTHER ADVANCES

During the past year, the Board has considered research progress and opportunities in three broad areas: inflammatory joint diseases; autoimmune disorders, in which the body's defense mechanisms attack the body's own tissue; and diseases that are characterized by the overproduction of collagen. The Board also considered research in sports medicine, acquired immunodeficiency syndrome (AIDS), and osteoporosis. The following examples describe recent research progress in these areas and opportunities for further advances through continuing research.

Rheumatoid Arthritis. Rheumatoid arthritis (RA) causes pain and inflammation in joints. If RA is not controlled, joint cartilage, tendons, and other surrounding structures are damaged. Deformity, loss of strength, and incapacitation are common. Treatment of patients' symptoms has improved with the development and more aggressive use of effective anti-inflammatory agents, with reduced incidence of side effects. These agents include gold salts, penicillamine, and methotrexate.

Recent evidence suggests that the nervous system may play a role in rheumatoid arthritis. A small protein produced by nerve endings has been shown to stimulate the cells of the joint lining to secrete a substance that promotes inflammation and another that destroys cartilage and bone.

Arthritis in Children. Several types of arthritis afflict children; some forms are unique to children. Considerable progress is being achieved on the immunogenetic basis for investigating arthritis in children. Researchers have found that juvenile arthritis is associated with several tissue-type antigens, linking juvenile arthritis to genetic factors. Pinpointing susceptibility to the disease on a region of a particular gene may lead to new therapeutic interventions.

Osteoarthritis. Osteoarthritis (OA), the most common form of arthritis, affecting some 16 million Americans, is a leading cause of pain and disability. Both the initiating events and the causes of the disease are not well understood. More than 150,000 total replacements of joints are performed each year in the United States, many as a result of osteoarthritis. New methods that allow observation of the body's responses to implantable materials at a cellular level will soon lead to the development of more acceptable and durable replacements.

Osteoporosis. Osteoporosis is an enormous public health problem, afflicting as many as half of all women in the United States over 45 years of age and 90 percent of women over 75. The direct and indirect costs of osteoporosis in this country have been estimated to be $7 billion to $10 billion annually. Researchers have identified three growth factors that relate to the decrease of bone mass in the elderly, and they are working to develop drugs to control the activity of these factors and ultimately to prevent bone loss. Levels of interleukin-1 are elevated in patients with osteoporosis, and those levels are reduced during treatment with estrogen and progesterone. Measurement of interleukin-1 may offer promise as a new marker for evaluation of the metabolic status of bone.

Musculoskeletal Fitness and Sports Medicine. NIAMS has initiated a research program in musculoskeletal fitness and sports medicine to provide a firm scientific foundation for training and rehabilitation programs.

Scientists have recently isolated a large protein complex from muscle that plays a central role in transmitting the excitatory impulse across membranes, ensuring uniform contraction of muscle. These studies are important to the regeneration of muscle and the response of muscle to exercise, benefits that may occur not only in well-trained athletes, but also in individuals with limited ability to exercise.

Epidermolysis Bullosa. Epidermolysis bullosa is a group of inherited diseases that affect the basement membrane zone of the skin and mucous membranes. By studying the molecular structures of the basement layer of the skin, researchers have found that most forms of EB are immunologic disorders that cause patients to develop antibodies to type VII collagen, a protein that forms the anchoring fibrils linking the inner and outer layers of the skin. These findings have made it possible to test therapeutic interventions such as phenytoin, a collagenase inhibitor.

Acquired Immunodeficiency Syndrome. Research on rheumatic and skin diseases as they relate to AIDS is increasing. NIAMS is collaborating with Walter Reed Army Medical Center to determine if examination of skin is useful for early diagnosis of subclinical systemic infections associated with AIDS.

Additional research is needed to better understand the co-occurrence of rheumatic diseases, such as Reiter's disease, and AIDS. HIV-positive individuals and AIDS patients present unusual opportunities for research. Further study may yield valuable insights into both the nature of AIDS and the nature of the skin and rheumatic diseases related to AIDS.

PROFESSIONAL AND PATIENT EDUCATION

The Board strongly supports the NIAMS programs that inform and educate health care professionals, the general public, and patients and their families about arthritis and musculoskeletal and skin diseases. The dissemination of scientifically accurate information in language appropriately targeted to these audiences is critical if research findings are to result in practical applications to treat, cure, and alleviate the suffering these diseases bring to millions of Americans.

SUMMARY

Much has been accomplished in addressing the problems of arthritis and musculoskeletal and skin diseases, but clearly there is a great deal yet to be accomplished and much work to be done. Last year, the Board testified that the Institute was "on the threshold of discovery" as a result of recent technological advances in such areas as molecular biology, immunology, bioengineering, and photobiology. In response to this challenge, the research community is pursuing new horizons in basic and clinical research. It is imperative that Congress appropriate funds sufficient to permit the Institute to keep pace with these opportunities and to undertake new initiatives so vital to research in arthritis and musculoskeletal and skin diseases.

STATEMENT OF IRVING AND GERTRUDE K. SWERDLOW, COFOUNDERS, FAMILIES AGAINST CANCER TERROR, INC.

Mr. Chairman, we want to thank you and the Committee for inviting us to submit our statement on cancer. We are Irving and Gertrude Swerdlow, co-founders of FACT, Families Against Cancer, a national organization of families that knows intimately the burden of cancer. Our program's purpose is to arouse the consciousness of the American people to the terrible costs and suffering related to cancer and to increase the resources that are made available to help the families affected by cancer. Research must open new avenues for intervention and the consequent reduction of cancer casualties.

Mr. Chairman, a serious lag exists between cancer statistics published by this Government on the one hand, and what this Government appropriates to the NCI on the other hand. For example, one billion dollars was appropriated in FY/80. During the following three fiscal years nominal monies actually declined, and increased only slightly in FY/84. For the fiscal years 1981 through 1989, monies increased about 40 percent while the CPI rose approximately 30 percent. Costs for medical technologies and professional services involved in the various research components rose by more than 40 percent, resulting in an actual decline of real, or constant dollars. Nearly four and a half million persons died of cancer in those nine years.

More than one million persons will be diagnosed as having cancer in 1989. In any one year, about five million cases of cancer are undergoing treatment. Already, the NCI goal to reduce cancer deaths fifty percent by the year 2,000 has fallen behind schedule and we are alarmed.

The people are fearful and angry. They are skeptical that the Government is committed to fight cancer as it would fight any other enemy that kills every 65 seconds. They want survival from cancer more than a 40-49 percent option. They know that a small fraction of one percent of a trillion dollar budget is inadequate to the problem. Support services to cancer patients and their families are essentially non-existent. Families endure stresses that frequently tear apart otherwise loving persons.

The federal budget continues to be an arcane instrument for many Americans. A trillion dollar budget is difficult to comprehend. How little of this trillion is allocated to fight cancer must become widespread public knowledge. Why is this nation's largest cancer center, the National Cancer Institute, receiving only a small fraction of one percent of the federal budget?

For one thing, the current NCI budget is commonly based on that of the previous fiscal year plus or minus a CPI adjustment. ~~(The CPI,~~ an urban worker's index, is not statistically significant for cancer research costs.) Federal health statistics provide a more realistic determinant of budgetary requirements: a half million deaths, more than a million newly diagnosed and five million cases undergoing treatment in 1989. Remember that a shortage of trained scientists and physicians to work for cancer research is not a restricting factor.

Second, the NCI appropriations are usually compared to that for all the Institutes of Health. Thus, the NCI is placed in a competitive position with other health services. Surely a trillion dollar budget can be more generous.

The myth prevails that the Government is doing all possible to cope with the mysteries of cancer. The time has come to inform the American public otherwise by equating the following costs with these NCI Appropriations.

1. A child born in the mid-80's has one in three chances of coming down with cancer in his lifetime;
2. A child born today has less than one in five chances of surviving cancer during his life cycle;
3. Cancer is the number one cause of death from ages 15-54;
4. It continues to kill more children than any other disease;
5. It is the number two killer after age 54, the "golden years", while it remains number one for our children and grandchildren.
6. Foregone earnings and medical care costs resulting from cancer exceed $75 billion annually;
7. Lost federal and state taxes approach $10 billion annually.

When we fight cancer, we tackle not one disease, but rather a whole family of diseases, all related by a process that causes human cells to disregard their natural growth signals. Each cell of the billions of cells in the human body has incorporated in its structure instructions that tell it how to grow, mature and, if necessary, to die and be replaced by another human cell. When these 'normal' cell instructions are altered, the cell often grows and multiplies in a wild manner, causing tumors that can often cause death. Sometimes, the tumor cells break off and travel through the blood stream until they attach themselves to another place in the body and continue to grow wildly. While the normal immune system usually attempts to fight off the efforts to change the growth instructions of the cell, its efforts are, too often, inadequate and tumors result.

During the past few years we have seen significant break-throughs. Some of these discoveries related to treatment or elimination of tumor growth; others have focused on how cancer metastasizes. Others relate to early detection. Some discoveries point to the use of specific anti-bodies to control cancer growth. Still others explore new means by which the immune system can be alerted to defend the body from cancer.

Every discovery opens new vistas for exploration and treatment. Every addition to the knowledge we have developed about how the normal cell grows and multiplies, how the immune system attacks and destroys invaders modifying the cells' growth instructions, requires additional studies and opportunities for new advances. Effective research must constantly grow both in complexity and depth of understanding. New methods must be developed. New equipment, particularly computers and scientific testing and analytical equipment, have lagged because so little has been budgeted for these purposes in recent fiscal years. Similarly, inadequate facilities, particularly research laboratories, has curbed critical research. Trained staff must be retained and stimulated by the vigorous pursuit of new ideas. When only 30-35 percent of approved research proposals can be funded, our efforts are obviously inadequate.

Avenues must be opened to make senior research staff at the NCI competitive with similar colleagues in the private sector and academia. An expanded program to defeat cancer will see young people gravitate to where those jobs are created. We have the talent. Let us put it to work for our needs. Don't let that scientific capacity die.

The costs of cancer in both human lives and in money are simply too great to be continued. Our society must try to evaluate more accurately what resources can be used, effectively , to fight cancer and make every effort to allocate these resources. We must make available all the resources needed to fight cancer and to cope with cancer. To do otherwise is costly in human capital, earnings, taxes foregone, and explosive medical care costs.

FACT, therefore, recommends approval of the NCI budget request for FY/90 of $2.2 billion, including $151 million earmarked for AIDS as basic and reasonable.

This is not a dream budget, but is realistic to the problem and to the Institute's capacity to make use of the money. The human capital is available to put these resources to use, immediately, against a brutal killer.

Too often, people on the Hill have questioned us: "Shall we take it from Mental health? from heart disease? from other NIH programs for cancer?" Certainly not. But appropriations relative to the existent dimensions of cancer must come about. What are these dimensions? Cancer will be experienced by 2 out of every 3 American families. It is one of the least discriminating forces in our society: it strikes male and female, caucasion, black and other races; rich and poor; young and old, and so often, those apparently in good health.

Increased funding to the NCI can be implemented by a judicious budgeting process that tightens up on inefficiencies and special interests. Many of the extensively financed budget items are totally unrelated to the saving of American lives. A vigorous war against cancer is incumbent upon a Government that already spends over one trillion dollars annually. It must respond to the pain and fear the people know. It must pursue discoveries in biological research.

FACT represented 5,000 persons in 1987 and 30,000 last year. Today it represents 50,000 and our grassroots organization continues its vigorous growth. The people will stand up and be counted and we will remind our Senators and Congressmen that cancer is not confined to a single State; that cancer is a national problem. Cancer must become a continuing national issue.

We sincerely ask your support for the proposed NCI Bypass budget of $2.2 billion. We thank you, Mr. Chairman and members of the Committee for your concern.

STATEMENT OF JEROME C. GOLDSTEIN, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF OTOLARYNGOLOGY

CHAIRMAN HARKIN, MEMBERS OF THE COMMITTEE, I AM DR. JEROME C. GOLDSTEIN, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ACADEMY OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY; AN ORGANIZATION WHICH REPRESENTS MORE THAN 8,000 AMERICAN OTOLARYNGOLOGISTS.

FIRST, ALLOW ME TO THANK YOU, ON BEHALF OF OUR ACADEMY MEMBERS, FOR YOUR LEADERSHIP IN CREATION OF THE NEW NATIONAL INSTITUTE OF DEAFNESS AND OTHER COMMUNICATION DISORDERS. BECAUSE OF YOUR WORK, THOSE WHO SUFFER FROM THESE DISORDERS IN OUR NATION, AND INDEED, THE WORLD COMMUNITY, WILL BENEFIT.

I COME BEFORE YOU TODAY TO SPEAK IN SUPPORT OF INCREASED APPROPRIATIONS FOR THE NEW INSTITUTE. THE ACADEMY WAS TREMENDOUSLY SUPPORTIVE OF YOUR CREATION OF THE NIDCD. THIS NEW INSTITUTE AT THE NIH IS A MAJOR STEP TOWARDS IMPROVING CARE FOR THE COMMUNICATIVELY IMPAIRED WHO FACE SERIOUS OBSTACLES IN TODAY'S SOCIETY.

DR. JAY MOSKOWITZ, IN HIS EXCELLENT TESTIMONY BEFORE YOU, HIGHLIGHTED RECENT ADVANCES WHICH CAN BE EXPLOITED TO ALLEVIATE SOME DISORDERS AND DISEASES OF COMMUNICATION. THESE INCLUDE SUCCESSFUL RESTORATION OF HAIR CELLS IN THE INNER EAR OF SOME ANIMALS, AND THE DEVELOPMENT OF THE COCHLEAR IMPLANT WHICH IS ALREADY GIVING RESTORED HEARING TO A FEW THOUSAND TOTALLY DEAF INDIVIDUALS. ADDITIONAL AREAS, INCLUDING BALANCE PROBLEMS IN THE ELDERLY AND LANGUAGE DISORDERS AMONG THE YOUNG, MUST BE EXPLORED MORE INTENSELY.

ALL THESE AREAS REQUIRE COORDINATED RESEARCH AMONG SCIENTISTS FROM MANY DIFFERENT DISCIPLINES. THE NEW INSTITUTE CAN PLAY A MAJOR ROLE IN EFFECTIVELY COORDINATING THIS RESEARCH.

DR. ROBERT J. RUBEN OF OUR ACADEMY CO-CHAIRED THE TASK FORCE ON THE NATIONAL STRATEGIC RESEARCH PLAN FOR THE NIDCD. THE PLAN CONTAINS A COMPLETE STATEMENT OF THE OPPORTUNITIES AND NEEDS OF THIS NEW INSTITUTE. THE $96,116,000 APPROPRIATION RECOMMENDED IN THE PRESIDENT'S BUDGET IS NOT ADEQUATE FOR THE NIDCD TO CARRY OUT THE MANDATE OF CONGRESS. NEXT YEAR, IN OUR PROFESSIONAL JUDGEMENT, THE INSTITUTE NEEDS FUNDS:

TO INCREASE THE NUMBER OF GRANTS FROM THE 1989 LEVEL BY %10.

TO INCREASE THE NUMBER OF CONTRACTS, ESPECIALLY THOSE TARGETED IN AREAS OF CLINICAL MEDICINE.

TO ESTABLISH NATIONAL TRAINING AND RESEARCH CENTERS AS CALLED FOR IN THE AUTHORIZING LEGISLATION.

TO ENLARGE THE INTRAMURAL PROGRAM OF THE NIDCD.

TO ESTABLISH DATA SYSTEMS AND POPULATION BASED STUDIES.

TO ESTABLISH A NATIONAL INFORMATION CLEARINGHOUSE FOR DEAFNESS AND COMMUNICATION DISORDERS.

AS YOU KNOW, MR. CHAIRMAN, ONE OF THE LARGEST PROBLEMS CONFRONTING THE NIDCD IS THE LIMITED NUMBER OF PHYSICIANS WHO ARE ALSO RESEARCHERS IN THE AREA OF COMMUNICATION DISORDERS. THE MOST OPTIMISTIC ESTIMATE IS THAT THERE ARE ONLY 50 SUCH RESEARCHERS IN THE ENTIRE COUNTRY.

FORTUNATELY, SOME OF THE BRIGHTEST AND BEST MEDICAL STUDENTS IN THIS NATION ARE CHOOSING OTOLARYNGOLOGY AND SEE THEIR CAREERS AS INVOLVING BOTH RESEARCH AND CLINICAL MEDICINE. WE MUST PROVIDE THESE YOUNG PHYSICIANS WITH INCENTIVES AND RESOURCES SO THAT THEY CAN FULFILL THEIR POTENTIALS AND ASSIST NIDCD IN ITS RESEARCH EFFORTS.

FUNDING RECOMMENDATION

OVER THE NEXT FEW YEARS, THERE MUST BE ONGOING GROWTH TO FULFILL THE MANDATE ENACTED IN PUBLIC LAW 100-533 WHICH CREATED THE NIDCD. FOR FISCAL YEAR 1990, WE RECOMMEND THE BUDGET FOR THE NIDCD BE SET AT $140,000,000 WHICH WILL BE WELL UTILIZED TO CARRY OUT THE RESPONSIBILITIES OF NIDCD.

FINALLY, I, BOTH AS AN INDIVIDUAL OTOLARYNGOLOGIST AND AS EXECUTIVE VICE PRESIDENT OF A NATIONAL MEDICAL ASSOCIATION, WOULD ONCE AGAIN LIKE TO THANK YOU, CHAIRMAN HARKIN, FOR YOUR EXEMPLARY EFFORTS BEHIND THE CREATION OF THIS MOST IMPORTANT INSTITUTE. WITHOUT YOU, THERE WOULD BE MUCH LESS HOPE FOR RAPID ADVANCES IN COMMUNICATIVE DISORDERS RESEARCH.

Senator Harkin, members of the committee, ladies and gentlemen: I am Dr. Jerome C. Goldstein, Executive Vice President of the American Academy of Otolaryngology-Head & Neck Surgery, Inc. which represents more than 8,000 otolaryngologists-head and neck surgeons in the United States. We care for patients of all ages who are experiencing problems with hearing, balance, voice, and who have benign and malignant tumors of the head and neck and who have allergic and cosmetic concerns involving these structures.

First, allow me to thank you, on behalf of our Academy members, for _your_ leadership in creation of the new National Institute of Deafness and Other Communication Disorders. Because of _your_ work, those who suffer from disorders in our nation, and indeed, the world community, will benefit.

I come before you today to speak in support of the new institute. The Academy was tremendously supportive of your creation of the NIDCD. This new institute at the NIH reflects a new national awareness of the substantial burden which diseases and disorders of communication place on an individual in contemporary society.

Our ability to communicate affects our well-being throughout our lives, whether as a two year old learning language, an adolescent furthering his/her education, a business person communicating with his/her associates and clients, or an octogenarian enjoying a conversation with his/her great grandchild on the telephone.

Dr. Jay Moskowitz, the acting Director of the NIDCD, in his excellent testimony before you, highlighted many of the scientific advances which have occurred in the past few years which can now be utilized to begin to alleviate some of the disorders and diseases of communication. These included the recent discovery that hair cells, the tiny sensory cells in our inner ears which are needed for hearing, can be restored after they have been destroyed in birds and some cold blooded animals. This information suggests that we eventually may be able to find a way to repair injury done to human hair cells by loud noises, poisonous substances, infections and genetic factors. As of now, very little can be done to help most people with sensorineural hearing loss. Finding ways to help those with this most common form of hearing disorder will require many highly trained and dedicated men and women who will undertake the extensive scientific investigations involving the sciences of molecular biology, genetics and embryology to extend these observations in birds and other animals to the special circumstances which are present in the mammal, and most importantly, in man.

Another area in which there is significant progress is the cochlear implant. This family of devices has already given aid to several thousand totally deaf people, but the instruments are still in the process of being perfected. This requires teams of specialized Engineers, Speech Scientists, Linguists, Otolaryngologists and Physiologists working together to develop equipment and strategies which will optimize the effect that these implants have. Much of the technology which will be developed will also be applicable to persons with lesser amounts of hearing loss who are now using conventional hearing aides. This endeavor will find application in many different types of communications from telephones to satellites, if there is the person power and the resources to develop the basic technology for compressing information into limited parcels which can than be maximally utilized.

In the elderly, balance disorders account for a large number of falls and consequent fractures of bones. Years ago, many older people died from pneumonia. Antibiotics have changed this. A major cause of death in the elderly today is related to a fall, experienced because of a balance problem. There is a need to find ways of correcting or compensating for these balance problems. We must find a way to keep them from falling so that they can enjoy their maturity. To do this will require cooperative research involving Anatomists, Physiologists, Otolaryngologists and Engineers.

Another area of great societal importance is language. The prevalence and incidence of language disorders appear to be greater than it was here-to-fore expected. Some language disorders are caused by quite modest hearing losses. In some children, even the slightest hearing loss may be associated with a substantial language deficit. Language abnormalities also occur as a result of environmental deprivation. The child with a language disorder has a most serious communication problem and will be unable to achieve his or her economic or personal potential. There is evidence, which needs to be verified, which indicates that many juvenile delinquents and criminals have communication disorders and that many of these are language disorders. Any part of crime which can be prevented by the elimination of language disorders will be a substantive gain for society. The pursuit of this research requires interdisciplinary cooperation between Language and Speech Scientists, Biologists, Psychologists, Sociologists, Epidemiologists and Otolaryngologists.

These are just a few of the important areas which have been identified for a commitment of national research resources. During January of 1989, Dr. Robert J. Ruben of our Academy co-chaired the Task Force on the National Strategic Research Plan for the NIDCD. The Task Force Plan contains a complete and comprehensive statement of the opportunities and needs of this new institute. The NIDCD has come into being. It now must have a chance to develop and grow. The $96,116,000 appropriation recommended in the President's budget is inadequate and insufficient for the NIDCD to carry out the mandate which Congress has given it. In our professional judgement, the institute needs:

1. To increase the number of grants from the 1989 level by 10% (The President's budget calls for a decrease in the number of grants from the 1989 level. There are more than enough applications with high priority scores to reach this goal of an additional 10%. Also, there are new scientists who have been attracted to the discipline because of the excitement of the science and the societal importance of the area.)

2. To increase the number of contracts, especially those targeted in the area of clinical medicine, with a view to looking at the efficacy of various interventions. (These are usually for clinical trials, which are costly, but provide society with an objective evaluation of the best ways to deliver applications of new scientific knowledge.)

3. To establish National Training and Research Centers as called for in the authorizing legislation. (At least 10 of these could be established in the next year.)

4. To increase the intramural program of the NIDCD so that it can undertake both basic and clinical research, serve as a resource for the NIH and provide a superb opportunity for

young men and women to work in the exhilarating and intellectually demanding environment of intramural NIH, as called for in the authorizing legislation.

5. To establish data systems and population based studies, as called for in the authorizing legislation.

6. To establish a National Information Clearinghouse for deafness and communication disorders, as called for in the authorizing legislation.

One of the largest problems confronting the NIDCD is the limited number of physicians who are also researchers. The most optimistic estimate is that within this entire country, there are only about 50 physicians who are doing clinical research funded by the NIH in the area of deafness and communication disorders. Most of them are funded by the NIDCD. I personally feel that even this number may be high when it is considered that a number of these physicians have two grants and some of the grants may not be entirely clinical. This is a dangerously low number of physician investigators. Additionally, there is a "greying" of the existing M.D. and Ph.D. investigators in the area of deafness and communication disorders and relatively few young recruits.

It is essential that we actively recruit and train more new investigators to continue the work which is becoming so promising. Fortunately, there are now many young men and women who are undergoing their five years of post-medical school clinical training in otolaryngology who stand ready to fulfill the need for clinical investigators. Some of the brightest and best medical students in this nation are choosing otolaryngology and see their careers as involving both research and clinical medicine. We must provide these young physicians with incentive and resources so that they can fulfill their potentials and assist NIDCD in achieving advances in the cure and alleviation of deafness and other communication disorders.

The establishment of the Research and Training Centers and a stronger Intramural Program will be of aid in recruiting these individuals. The NIDCD administrative staff has already made a contribution to the effort by announcing new programs and by being available to speak with young members of the research community. This effort has already resulted, in my own experience, in more young people orienting themselves to investigatory careers in deafness and other communication disorders. The growing awareness and excitement must be followed up by substantial additional funds for the training of all types of scientific workers in the area of deafness and other communication disorders. This is one of the highest priorities for the new institute.

Funding Recommendation

It is recognized that all of this cannot come about in one year. Over the next few years, there must be ongoing growth to fulfill the mandate which has been enacted in public law 100-533, which created the NIDCD. For the fiscal year of 1990, we recommend the budget for the NIDCD be set at $140,000,000 which will be well utilized to carry out the existing responsibilities of the NIDCD and allow a start to be made in recruiting and training additional investigators.

Finally, I, both as individual otolaryngologist and Executive Vice President of a national medical association, would like to thank you, Chairman Harkin, for your exemplary efforts behind the creation of this most important institute. Without you, there would be much less hope for rapid advances in communicative disorders research.

STATEMENT OF BOWLEY N. MOORE, NEW HOPE PARENTS ASSOCIATION

Mr. Chairman, my name is Bowley N. Moore. I am here again this year to speak to you as a parent of a child with a developmental disability and as the Eastern Regional Director for the New Hope Parents Association (NHPA). As an advocacy agency, the primary objective of NHPA and its affiliate, the New Hope Research Foundation, is to provide state-of-the-art information about effective treatments and services for persons with developmental disabilities.

We strongly believe that this objective can best be met by promoting research that is directly relevant to persons with developmental disabilities and their families. We are grateful for the opportunity to share our views about federal support for the developmental disabilities research program of the National Institute of Child and Human Development (NICHD) and the National Institutes of Health (NIH).

As vested observers of national polices related to improving the lives of persons with developmental disabilities, we are well aware that the NIH regards basic science as its primary mission. Of course, we understand that basic science is a vital and essential component of the overall research endeavor. Yet as a parent of a disabled child speaking as a representative of thousands in similar circumstance, the daily problems of coping and adapting are real, are difficult and press heavily upon the family and resources. Cytogenetics research is important, but no less so than the quality of life issues that beset so many and at such great cost. Clinical and applied research has some support but traditionally it has taken a "back seat" to basic research. The NICHD, as an administrative entity of the NIH, emulates the orientation of its parent agency. Basic science is stressed and is fostered, for example, by selection of grant reviewers who are identified with basic research and all too often have little if any experience with and knowledge about developmental disabilities. This approach has the historical and uncompromising support of a small but vocal community of basic scientists and their respective universities. Historically, basic scientists and their universities have been supported by the flow of federal funds for research and have been extremely powerful in shaping national research priorities in the area of developmental disabilities.

In contrast, parent and professional groups who advocate for persons with developmental disabilities and who represent many more citizens throughout this nation, have traditionally had much less influence in providing direction to the research efforts of the NICHD. Except by our votes we do not have the persuasive words and political infrastructure of those who advise government on the creation of research policy. Because people with developmental disabilities have many special needs, advocacy groups are greatly concerned with clinical and applied research which has direct and immediate benefit for their children and families. We contend that as parents of children with developmental disabilities we are the most important consumers of knowledge related to developmental disabilities. Moreover, with respect to formulating research policies, we are entitled to and should be active participants in shaping the research agendas of the NICHD, particularly in regard to any new monies that are allocated by this Congress. This is not to say that we want the final decision as to whether a particular study or program is "good or bad" research. Rather, we ask the Congress to insist that NICHD administration take a leadership role in facilitating research that is of direct relevance to and of more immediate benefit for persons with developmental disabilities and their families. Our concerns embrace the NICHD mental retardation research program as a whole, the performance of the national network of Mental Retardation Research Centers, and the Intramural Research Program. We want to express our support for a broad-based effort, but one that recognizes the needs and concerns of those who must live with disability. We pay the freight; we should have a greater say in what gets delivered.

The NICHD Mental Retardation Research Program

Progress leading to the resolution of problems associated with developmental disabilities has been, and will probably remain, painfully slow. There are many different types of developmental disabilities and hundreds of causes and many effects. Yet hope for accelerated research advances was kindled in 1962 when Congress created the NICHD - a new institute with major responsibility for research in developmental disabilities. Further encouragement was found in congressional action, taken in 1963, to appropriate funds for the construction of "centers for Research on Mental Retardation and Related Aspects of Human Development"(MRRCs). A decade of accelerated and expanded research in developmental disabilities followed until 1974 when the administrative leadership of the NICHD changed. Since that time funding for research in developmental disabilities, both in grants and contracts, and in MRRC core support has declined steadily relative to other NICHD programs and commitments reaching an all-time low in 1989. What do these trends say of our hopes, of our national resolve, and of the lives of our children ?

Mental Retardation Research Centers

When Congress acted, in 1963, to create Centers for Research on Mental Retardation and Related Aspects of Human Development (MRRCs), advocates for the mentally retarded shared the widely held view that Congress intended these centers to have a mission that focused on mental retardation research. Unfortunately, over time it appears that mental retardation research in the MRRCs has become less of a central focus while the related aspects of human development have received increased attention. Much of what is called "mental retardation" research by NICHD is so general and generic in nature that the connection to mental retardation is neither direct, nor clear, nor convincing. The result has been further deterioration of research relevant to developmental disabilities. The human cost is that our children and families are increasingly left to a hollow and discouragingly vague promise.

NICHD Intramural Research program

Research emphasis on mental retardation in the Intramural Research Program has shown a remarkable decrease in previous years. In its first decade, the NICHD supported 3 intramural branches (laboratories) whose work was directly related to developmental disabilities. Today, none is identified as having concern for mental retardation research.

Conclusion

In summary, in the last decade we have seen an erosion of federal support to develop knowledge related to developmental disabilities. Moreover, all too often, the funds allocated have been used for endeavors that are of little relevance to and beneficial for families who are rearing children with developmental disabilities. The NHPA recommends increased funding for NICHD sponsored research provided that a significant amount is allocated to conduct and support applied and clinical research that is relevant to developmental disabilities and is of more immediate benefit to families with children with developmental disabilities. We do so with the hope that the Congress will consider our concerns for NICHD operations and provide appropriate oversight and guidance to the administrators.

We also strongly believe that Congress should take a leadership role in approving increases for applied and clinical research for the developmentally disabled as they have done for the AIDS population as there are over 6 million people involved.

With regard to NICHD appropriations we specifically recommend the following:

1. An appropriation, excluding the AIDS component, of $534,102,000 in FY 1990, as contrasted with the $403,475,000 appropriated in FY 1989.

2. An increase in the center line to $44,200,000, in FY 1990 in contrast to $33,613,000 in FY 1989.

3. Increase in the center (MRRC) line should be: (a) used to fund 3 new mental retardation centers, raising the total to 15 centers. (b) a new learning disabilities center and (c) reduce eliminated negotiated reductions in core support to the existing centers.

4. The total number of research grants, noncompeting and competing should be increased from 1713 in FY 1989 to 1881 in FY 1990, excluding AIDS projects.

5. The number of research trainees supported by NICHD should be increased from 629 in 1989 to 850 in 1990, again excluding AIDS.

6. That report language be crafted to indicate congressional concern for these increases in such a way as to leave no doubt as to intent. By its language we ask you to ensure NICHD's commitment to developmental disabilities, especially retardation, and that a documented effort be initiated to increase support of research directly relevant to children and their families.

We ask, also that one of the new centers should focus its efforts on Down Syndrome and related chromosomal disorders. Down Syndrome is the most common genetic cause of mental retardation. Specifically, this center should conduct clinical and applied research for the cure and treatment of the developmentally disabled and provide dissemination of state-of-the-art information concerning Down Syndrome and related chromosomal disorders.

We do not ask the Congress for entitlements to subsidize or support our children. We do, however, ask Congress to provide the leadership, direction, and additional monies to return the developmental disabilities research program of the NICHD to its original congressionally mandated purpose of supporting research that is relevant to developmental disabilities.

President Kennedy was clearly expressing this idea when he signed Public Law 88-164 creating the MRRCs and said, "For the first time parents and children will have available comprehensive facilities to diagnose and either cure or treat mental retardation...No longer will the mentally retarded be alien to our affections or beyond the help of our communities." That vision, shared by Congress, has in our view, been dissipated. We strongly believe that the time has come for Congress to take steps to fulfill promises made over twenty years ago. By doing so, you can positively affect hundreds of thousand Americans with developmental disabilities and their families. We are increasingly concerned and we plan to assume a stronger voice in this process.

STATEMENT OF BARRY R. KOMISARUK PH.D., PRESIDENT, NATIONAL PROGRAM DIRECTORS ORGANIZATION

I represent the Directors of 98 MBRS Programs nationwide that support more than 1500 Minority students -- graduate and undergraduate, utilizing an annual budget in FY 1989 of $ 38.7 M ($28.1 M from DRR + $10.6 M cofunding).

My objective in this presentation is to convince you that a crisis in manpower is going to strike this Nation in a decade, and that by increasing your appropriations now to the MBRS Program you could substantially reduce the severity of that impending crisis.

What is the MBRS Program?

It is funded by the NIH and emphasizes hands-on laboratory research experience for Minority undergraduate and graduate students, while supporting the development of advanced biomedical research capability in the institutional infrastructure. It does this in the HBCU's (Historically Black Colleges and Universities), from which graduate almost 50% of the Minority students who enter careers in biomedical research, and in Majority Institutions that serve significant numbers of Minority students -- primarily Black, Hispanic, American Indian, Alaskan native, and Asian or Pacific Islander. It provides the students the opportunity to experience for themselves the excitement of making a scientific discovery and becoming an author. Thus it opens the door for Minority students to enter the mainstream of biomedical research in the United States.

The MBRS Program pays graduate students $5,640 per year and undergraduate students $4,200 per year. Graduate students also receive tuition and fees. All students receive $600 per year to attend a scientific conference where they can present their research findings.

The MBRS Program was created by Congress in 1971 to remedy an underrepresentation of ethnic Minority reseachers in biomedical research careers. At that time, Minorities constituted 15-20% of the U.S. population, but only 1-2% of the biomedical researchers. Since then, it has funded 16,000 Minority research participants, 80% of whom are now in the pipeline as the U.S. biomedical researchers of the future. By 1987, 16 years after its founding, the MBRS Program counted 1,078 doctorate degrees awarded to Minority students whom it had supported (degree types: M.D.: 71%, Ph.D.: 24%, D.D.S.: 5%). This is an outstanding track record.

What is the impending National manpower crisis?

Only 11 years from now, there will be 22% fewer 18 year olds than today in the U.S. A greatly increased proportion of the school age population will then be Minority -- about 1/3. That will create a much greater dependency on Minority student entrants into the work force. But based on present trends, they won't have been taught the skills needed to qualify for the job positions that will need to be filled. For example, U.S. Secretary of Education, Lauro Cavazos, stated that less than half as many Minority students as White students take all their required science courses in high school. This is a poor contrast with the years of science training that students receive in the USSR.

Worse still, the dropout rate of Black students in many inner city schools is 50% or greater. For the Minority students who don't drop out, there is a new hurdle: the cost of college. Over the last few years it has been increasing at more than 2 times the rate of inflation. Compounding the problem, Federal grants and scholarships plummeted from $13 Billion in 1975 to only $5 Billion in 1985. It is no surprise that a recent Ford Foundation report concluded: "the flow of Minorities through the educational pipeline has been reduced to a trickle by the time the students are ready to attend graduate school."

The handwriting is on the wall -- unless the U.S. acts now to reverse this disastrous trend at the National level, in just one decade there won't be enough educated and skilled citizens in our Nation to make it competitive with the rest of the world.

Are we going to sit back and wait for another "Sputnik" -- this time a biomedical one -- such as an anti-cancer vaccine from Japan or a cure for the common cold from the USSR -- to spur us into action again? It would take years for the U.S. to catch up. But we can avert a crisis like that if you will take the necessary steps now to increase the flow of Minority students into the pipeline.

The MBRS Program has been extraordinarily effective in generating highly skilled and educated Minority scientists. However, over the past 5 years, there has been a relative contraction of the MBRS Program of over 5% on a per student basis and over 9% on a per program basis. Thus, worthy programs are going unfunded; worthy students are dropping out. A substantial boost in the funding level of the MBRS Program is needed and justified. But at a time when this boost is needed so critically, less than a $ 1 M increase in the budget for FY 1990 has been requested. What is needed? The MBRS Program Directors' Organization recommends the following:

1. Increase the number of MBRS Programs funded Nationwide.

The number of MBRS grant applications worthy of funding has increased in recent years but the funding has not kept pace. As a result, hundreds of Minority students are being denied the opportunity of working in the MBRS Program and are being turned off to careers in the biomedical sciences. The estimated cost of funding the approved grant applications: $8.0 M.

2. Increase the student salary scale to realistic levels.

Despite the recent salary increases, the MBRS is still not financially competitive with other Federal, State and University agencies in terms of level of student support. The current MBRS graduate student salary is only $5,640, whereas graduate students now commonly receive an annual stipend of $12,000. The estimated cost for the current MBRS graduate students to attain parity with competitive Programs: $5.0 M.

3. Reinstate MBRS Initiatives discontinued due to fiscal constraints

These are the "Instrumentation Initiative," that would provide much needed state-of-the-art research equipment, and the "Thematic Initiative," that would facilitate research on complex problems requiring the powerful interdisciplinary approach. Estimated cost: $2.0 M.

4. Launch the Pre-College Initiative

The National Advisory Research Resources Council and the MBRS Program have recommended the Pre-College Initiative, which is directed toward MBRS grantee Institutions. The Initiative would motivate high school students for a career in biomedical research by involving them in exciting outreach activities such as visits to laboratories, science workshops, etc. The MBRS Institutions are in a unique position to serve as magnets to attract high school students, because the MBRS college students are already in place as excellent role models. Furthermore, the MBRS Institutions focus the effort; they target the Traditionally Black Institutions (TBI's), of which (in 1981) 84 produced more Black baccalaureates than all the other 673 Institutions in TBI states. Estimated cost for this first step: $2.5 M.

What Action is required?

The cost of implementing all the above Programs is $17.5 M. In the quest for excellence, innovation, competitiveness and productivity in this Nation's biomedical research effort, the MBRS Program is an essential National resource that must be protected, cultivated, and adequately funded. We urge you to appropriate this increase in the NIH budget to supplement the MBRS Program for FY 1990. The benefit to the Nation in terms of generating Minority biomedical scientists will be well worth the investment. The cost will be low; the returns, great.

STATEMENT OF NATIONAL COALITION ON IMMUNE SYSTEM DISORDERS

The National Coalition on Immune System Disorders (NCISD) is an organization comprised of a variety of national voluntary and professional groups interested in the human immune system, including the American Academy of Otolaryngology-Head and Neck Surgery, American Diabetes Association, Arthritis Foundation, Immune Deficiency Foundation, Lupus Foundation of America, National Foundation for Ileitis and Colitis, National Multiple Sclerosis Society, and the American Association of Immunologists.

NCISD's statement will address funding requirements for the National Institutes of Health as they relate to the 65 million Americans with immune system disorders--diseases and conditions which include AIDS, allergies, diabetes, multiple sclerosis, arthritis, lupus, immune deficiency, and a host of others.

At the outset we want to thank this Committee and the Congress for your support for the nation's research in the field of immunology. You have been sensitive to the need for expansion of research efforts at a time when knowledge in the biomedical sciences is experiencing a virtual explosion. The funding you have provided will pay great dividends in the health of the American people, through early detection of disease, prevention and cure, better disease management, and improved quality of life for millions.

Research efforts concentrated on AIDS can benefit other immune system disorders, and this Committee is to be commended for its support of AIDS research. At the same time, we urge that you work toward a funding level for NIH that will assure adequate research in all diseases and disorders of the immune system. We are deeply concerned that the President's FY 1990 budget requests a percentage increase for non-AIDS immune system research which is lower than for NIH as a whole, and which will result in severe cuts in all research project grants.

In terms of overall NIH funding for FY 1990, the coalition endorses the recommendations put forth by the Ad Hoc Group for Medical Research Funding; we agree that the total amount appropriated for the National Institutes of Health should be $8.4 billion. Research projects grants at this level would be fully funded, with an award rate of 33%. The NIH research institute most broadly involved with immune system research is the National Institute of Allergy and Infectious Diseases. The President's budget for FY 1990 requests $442.6 million for non-AIDS research at NIAID, and $400.1 million for AIDS research, the NIAID portion of the total AIDS budget.

NCISD urges this Committee to recommend enactment of appropriations for NIAID which reflects the professional judgement of eminent scientists in the field of immunology. We urge you to provide $630.5 million for non-AIDS activity at NIAID, including $442 million for research project grants, $20.4 million for centers, and $16.6 million for research training. At this level no reductions would be necessary in study section-approved grant amounts for research project grants and centers. In addition, other important research efforts in non-AIDS related immunology could be expanded or initiated.

It is important for the members of this Committee to understand some of the research currently underway at it affects the member organizations of NCISD. The Immune Deficiency Foundation notes that the expansion of knowledge of the primary immune deficiency diseases (those in which genetic and metabolic abnormalities result in a defect in one or more components of the immune system) has led to the development of several beneficial therapies. Among these are bone marrow transplantation and intravenous gamma globulin replacement. One of the severe combined immune deficiencies, ADA Deficiency, is one of the likely first candidates for correction by the new technique of gene therapy. IDF stresses the importance of basic immunologic research and, in particular, the funding of studies on congenital immune deficiency and on developmental immunology.

There are few research areas pertaining to connective tissue that have engendered more interest and results during the past decade than the study of systemic lupus erythematosus (SLE). The Lupus Foundation of America notes that immune system studies have led to the discovery of abnormalities that may be important clues to finding the causes of lupus. These are essential to determining how lupus might be prevented, how to design improved treatments that alleviate symptoms, or attack the disease itself. The results of such research projects are being applied to the lives of people with lupus. For example, NIH research recently identified a new treatment for lupus patients with kidney involvement (lupus nephritis) who do not respond well to traditional drugs. The use of low-dose, pulsed, intravenous cyclophosphamide is more effective in treating the complication.

The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) notes the need for more funding for research into the causes and prevention of otitis media (inflammation of the middle ear). This painful disease results in 30 million doctor visits per year and its costs $2.5 billion a year to treat. The Academy recommends increased funding in two specific areas. The first area is the search for a vaccine to prevent the initial contraction of otitis media. Little otitis media vaccine research has been done since the early 1970's.

The Academy also supports increased funding for research to identify children at chronic risk for otitis media. Seventy percent of all children in the U.S. experience at least one episode of middle ear inflammation before age 3. If chronically stricken with the condition, a child can suffer permanent hearing loss. This tragic consequence is preventable if the condition is diagnosed at an early stage and treated accordingly. Thus the ability to identify these children who are the most susceptible to this condition would enable the medical community to mitigate the frequency of communicative disorders among our young as well as relieve much of their pain and discomfort.

The Arthritis Foundation has a deep interest in appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). This derives from its commitment to the more than 38 million Americans who have arthritis. Research and training supported through this new NIH institute has direct and profound effects on people with arthritis. The Arthritis Foundation asks that you support funding of $192 million for NIAMS for FY 1990. This appropriation reflects funding for research programs which should be funded based on scientific judgement. We need this level of funding to produce an adequate supply of scientists in the field of arthritis and to fully continue the efforts of arthritis research.

Research over the past twenty years has provided firm evidence that multiple sclerosis (MS) is in all probability an autoimmune disease characterized by destruction of the myelin sheath. The course of MS is attacks followed by remission. Attacks often seem to occur without warning, but there are two known triggers: infectious illnesses which are known to disturb immune system balance, and the administration of gamma interferon, a modulator of the immune system. The National Multiple Sclerosis Society notes that research has evolved to the point where extensive clinical trials of promising immune system treatments are underway which may tilt the subtle balance toward control. The Society urges support for additional research in addressing immune system-nervous system interaction, stress and immune disorders, and other important efforts to prevent, better treat, and cure MS and other serious diseases and disorders.

Diabetes is a serious, chronic disease and is a major cause of death and disability. The American Diabetes Association notes that much progress has been made in scientific understanding of the genetic influences involved in the disease. Patients with insulin dependent diabetes are usually subject to associated autoimmune diseases such as those affecting the adrenal gland cortex and gastric mucosa. ADA supports increased funding for the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) and other NIH institutes for additional individual research grants, research training, and centers. There is particular need for incentives to support physician scientists in basic training programs and for independent study.

A major goal of the National Foundation for Ileitis and Colitis is to promote interaction between basic and clinical investigators. Inflammatory bowel disease, including ulcerative colitis and Crohn's disease, is an immune system disorder which is susceptible of study following the same principles as other immune-related disorders and diseases. In the future, continued interdisciplinary research activities that involve basic immunology applied to mechanism of intestinal inflammation and development of pharmacologic agents which will accurately inhibit these processes will lead to continued improvement in our understanding and treatment of inflammatory bowel disease and other immune system disorders.

Mr. Chairman and members of the Committee, thank you for affording the National Coalition on Immune System Disorders the opportunity to present this statement on the need for additional immune system research.

STATEMENT OF NORTON NELSON, NEW YORK UNIVERSITY MEDICAL CENTER

My name is Norton Nelson. I am Professor of Environmental Medicine in the Institute of Environmental Medicine, New York University Medical Center. I was Chairman of the Department of Environmental Medicine and Director of the Institute of Environmental Medicine for 26 years, a position I relinquished some nine years ago. I have been succeeded by Dr. Arthur Upton, former Director of the National Cancer Institute. I remain full-time in teaching and research in the Institute.

I am here to testify on behalf of the Association of University Environmental Health Sciences Centers (AUEHSC); Dr. Upton, President of the Association, was unable to appear and has asked me to speak in his place. This Association represents 16 university-based research Centers throughout the United States, of which 11 are biomedically oriented and 5 focus on the relationship between health and the quality of fresh and marine water. These university-based Centers receive support from the National Institute of Environmental Health Sciences (NIEHS) and represent a continuity of research and clinical expertise in the field of environmental health which is both unique and not easily replaceable. The Centers serve as a core around which a group of distinguished faculty from various sections in a university can conduct research and training in a broad spectrum of environmental health sciences.

The university-based Centers are at Duke University, Harvard University, Johns Hopkins University, Massachusetts Institute of Technology, Mt. Desert Island Biological Laboratory, Mt. Sinai School of Medicine, New York University Medical Center, Oregon State University (2), the University of California at Berkeley, the University of Cincinnati, UMD New Jersey Robert Wood Johnson Medical School, the University of Rochester Medical Center, the University of Connecticut, the University of Wisconsin at Milwaukee, and Vanderbilt University.

Concern for the impact of environmental factors on health has not waned but has in fact increased steadily over recent years. A major need in this country is to have cool and deliberate factual, objective evaluations of the extent of the hazard, and not one driven by extreme headlines or by needless panic responses. In short, we need a reliable estimate of the weight of a suspected problem and means for its correction. For such a stance to be successful, it must have trustworthy information. A main purpose of the Centers of Excellence established by the National Institute of Environmental Health Sciences is to aid in providing the kind of objective information on which reliance can be placed.

The concept of establishing a modest number of Centers of Excellence in the universities of the United States goes back several decades when the late Representative John Fogarty chaired this sub-committee. Mr. Fogarty was very aware of the issues of environmental health and tock a major part in making proposals for the early development of a national program. He recognized the need to keep alive sparks of talent and interest in the universities through the establishment of Centers of Excellence.

The development of these Centers has been a careful, deliberate and meticulously reviewed approach starting in the 1960's. The present sixteen Centers extend across the land in major universities from coast to coast. They have provided, and continue to provide, a major resource in a problem area in which facts are scarce (but can be found) and rumor is rife and often erroneous. These Centers have three major objectives; first, to develop the knowledge on which judgments must be based as to the importance of the threats of environmental factors on health; a second is to provide training for new recruits to the field and to replace the scientists as they complete their careers; the third objective is to provide service to the nation and to supply trained scientists to industry and to the government. Service is provided in many forms to the nation. Among them, service in field studies often in collaboration with groups outside the Centers themselves, and membership on advisory committees to our national and state regulatory agencies and health departments, and to industry.

The Centers recruit scientists of quality who become experienced in various aspects of the field through training and research in the different

Centers. The Centers thus provide much needed career stability for a modest number of scientists in the nation who will devote their careers to the field of health and environment. When new issues emerge, they can quickly regroup their forces to deal with them promptly and effectively. Thus, the Centers provide a stable source of expert science with sophistication growing out of experience and specialized training. It might be said that this nation leads the world in environmental health, and the Centers have contributed significantly to this leadership.

It should not be supposed, of course, that all relevant research is done through these Centers. Much valuable research is underway elsewhere in universities. However, the Centers provide a continuing stimulus to their own universities and others. A significant magnification of research support above and beyond the Center grants themselves, comes through additional grants and contracts: the multiplication factor of this additional research support probably averages 3 or 4 times the monies awarded by NIEHS in the form of core support to the Centers. The Centers see their mission as using the best of evolving basic science to gain an understanding of the extent and importance of environmental factors in the causation of disease.

Training of scientists to specialize in environmental health occurs in all of the Centers. In our own Center at New York University Medical Center, for example, we have awarded some 130 Ph.D. degrees over the 41 years of our existence. All of our former trainees have remained in the field, productively employed in government, industry, or academic institutions.

This nation is in an extremely competitive world, with rapidly growing numbers of industrialized neighbors across the seas. Any technology that is known to lead to adverse effects is a serious detriment to successful competition. A technology that weakens the ozone layer cannot be tolerated, with the result major steps are already being taken to correct the existing situation. Global warming is now regarded as a reality, with its pace being the only major uncertainty. In our present complex situation, where knowledge is our only defence, the Centers of Excellence of NIEHS provide a major resource.

Only a few examples of research in the Centers can be covered here; the examples represent only a small fraction of their activities. For example, our evaluation of the health impacts of air pollution has required stable support over a continued period of time in order that the actual impact of air pollution on health can be assessed. One of the Centers has been involved in the so-called "Six Cities Studies" over 12 years, which has provided the most definitive information yet available on health effects of air pollution. On the basis of this information, the Center is now expanding its studies to cover 24 cities in order to refine some of the observations that have been raised.

Another example concerns the study of lead, which has been recognized as poisonous for many centuries but has been found in recent years to cause learning defects in the young, even at comparatively low levels of exposure; this has led to expanded study of the health hazards of this metal. Also, although much progress has been made in evaluating the health impacts of other environmental pollutants, pesticides, and food contaminants, much remains still to be done to give the confidence which is required in this important field.

Listed below are some additional selected highlights identifying activities of the Centers relevant to the health impacts of environmental factors. Obviously, they represent only a fraction of the total activity of these very active groups.

Highlights of Research in the Centers

- Conducting one of three national urban lead abatement projects (soil, pavement, interior) aimed at defining means for reducing blood lead in children. (Univ Cincinnati)

- Research on genetics of fish parallel to human induction of neoplasms and renal elimination of toxic pollutants. (Univ Conn)

- Research suggests rainbow trout as most sensitive species for detection of carcinogens in human dietary factors and in polluted waterways. **(Oregon State Univ-Marine)**

- Aiding FDA in setting standards through studies on humans exposed to methylmercury in fish. **(Univ Rochester)**

- Epidemiological studies on lung cancer, radon and asbestos, pregnancy loss in women using video display terminals, neurologic impairment from exposure to solvents and lead. **(Mt. Sinai)**

- In collaboration with the Center for Great Lakes Studies (and independently) examining mode of action of metals, especially lead and cadmium on neurobehavioral effects (as parallels to human effects) in aquatic systems including interaction of toxicants with soils and sediments. **(Univ WI-Milwaukee)**

- Chronic exposure to ethylene oxide (widely used as hospital instrument sterilant) may lead to genetic injury to blood cells persistent for six or more years; have observed that machinists exposed to cutting oils and coolants may show loss of lung function. **(Harvard)**

- Developing techniques for estimating uptake of reactive and genotoxic chemicals and applying these to blood donors. **(MIT)**

- Oncogenes have been detected in human arteriosclerotic plaques supporting hypothesis on mutational mechanism in plaque formation. A major new program on health and ecological studies on Superfund hazards is now underway. **(NYUMC)**

- A simple cloning technique using blood lymphocytes measures DNA repair capability and promises means for estimating individual susceptibility to cancer. Another technique shows likelihood of lung cancer several years before clinical evidence. **(Johns Hopkins)**

- New methods for detecting mutagen adducts from DNA and excreted in human urine have been developed and also measured these adducts in the DNA of rats; these methods show that oxidative damage is very high in humans and may be related to aging and cancer. **(Univ CA-Berkeley)**

- Studies have led to the synthesis and identification of the most toxic form of aflatoxin, a common contaminant of corn and peanuts and a potent liver carcinogen; proteins that activate these compounds and 15 other carcinogens have been characterized; inter-individual differences may be important in predicting why some people are more susceptible to cancers than others. **(Vanderbilt)**

- A new thecretical metabolic mode of action of benzene, a proven cause of human leukemia, is consistent with damage to the bone marrow and suggest that biomarkers of exposure can be improved in sensitivity and specificity. **(UMDNJ-R.W. Johnson Medical School-NJ)**

- Improvement in cell culture techniques expand possible use of human cells from blood and surgical specimens. Studies on widely used pentachlorophenol improve knowledge of health effects and fate in environment. **(Oregon State Univ-Health)**

Thus, the needs are substantial; increased knowledge continues to be sought, but resources are limited. The program has worked well, and we believe that this has more than proven its utility. The present annual budget for the Centers is approximately $16 million dollars. The support available to the National Institute of Environmental Health Sciences has had virtually no increase in recent years, requiring the imposition of a cap on the awards to major Centers since 1981. The funds needed to maintain the freshness of talent and the full activity of the program has been severely impaired by the presence of this cap. Virtually every university is under an imposed in-service and merit increase of approximately 6% per year. To maintain vigor and freshness of Center staff, there should have been a corresponding inflationary adjustment of approximately 6% per year since 1981. The absence of such an adjustment has been a very, very substantial burden for the major Centers. The net consequence is uncomplicated but brutal; namely, that staff reduction must be undertaken. In university systems, the only flexibility in regard to staff reduction is through release of young faculty on the way to tenure but still untenured. Reduction of the staff at this level means they we are cutting off the very freshness which is needed to keep the Centers vigorous, vital and in tune with the growth of knowledge. The end result can be only a dwindling in staff productivity and a reduction in the introduction of new talents and new ideas.

We realize that these are difficult times. We are very aware of the budgetary problems confronting this committee and the federal government in general. We would certainly not wish to see any of the programs in NIEHS sacrificed to correct this growing gap between what is needed and what is now available. This means that we come to you hoping that this committee can find ways to provide additional funding to stem this drift. We thus request the committee to increase the Center funding by $4 million, increasing Center support from $16 million to $20 million dollars.

We believe that this program is a vital one to the health of the nation and to its economy. We believe that the contribution to the nation far outweighs the current funding; we would hope that the budget of the Institute itself could receive some additional strengthening.

This committee over the years has been very supportive of the program, we hope, it may be possible for that to continue and indeed, we are convinced that you will go as far as you can.

I thank you very much for your attention to these comments.

STATEMENT OF SANDRA W. SCARR, PH.D., ON BEHALF OF THE COUNCIL OF GRADUATE DEPARTMENTS OF PSYCHOLOGY

Mr. Chairman and Members of the Subcommittee: I am Sandra W. Scarr, Chair, Department of Psychology, University of Virginia. I appreciate this opportunity to provide this testimony of behalf of the Council of Graduate Departments of Psychology. Our testimony is also supported by the American Psychological Association. I will focus on appropriations for the National Institutes of Health (NIH) and specifically the need to increase the proportion of funding for research on health and behavior.

NIH HEALTH AND BEHAVIOR RESEARCH

In response to evidence that developments in many fields of biobehavioral sciences have great potential for improving the diagnosis, prevention, and treatment of illness, in recent years this Subcommittee has directed NIH to increase its support for health and behavior research and to report back to Congress on its progress in this regard. I would like to commend you, Mr. Chairman, and the Subcommittee for your continued support for NIH funded research on the role of behavioral and social influences on health promotion and disease prevention.

In this year's health and behavior report to Congress, NIH indicates that in fiscal year 1988 it spent $197 million, or 3.17 percent of its $6.2 billion budget, on health and behavior research and research training. Although this represents an increase over previous years' funding, the proportion of the overall NIH budget devoted to the health and behavior research agenda has remained relatively constant in recent years at 3 percent of the total NIH budget.

As the nation's largest source of funding for basic research on health and disease, NIH has a special responsibility to heed the findings of the Institute of Medicine's report Health and Behavior: A Research Agenda, which NIH cosponsored. This report identified lifestyle and behavioral factors as the major causes of death in the U.S. Similarly, it has become clear that the most significant way to reduce the AIDS pandemic is to educate people on changing behaviors and lifestyles. NIH is to be commended for its health and behavior work in these areas, but more resources are needed. We recommend that NIH establish each year meaningful and explicit goals to raise its expenditures for health and behavior research from its current proportion of three percent to a target level of ten percent.

NIH RESEARCH TRAINING

Additionally, we recommend a substantial increase in the number of NIH-supported research trainees. We urge the Subcommittee to provide research training funds sufficent to enable NIH to specifically enhance research training opportunities for behavioral scientists. The recent Congressionally-mandated stipend increase, because it was not accompanied by the necessary additional funds to pay for the increase, has resulted in a reduction in the number of trainees and has necessitated closing down programs, not expanding them. As we plan for higher rates of attrition among senior scientists, and because of the long lead time needed to develop skilled researchers, the Council recommends a significant increase in research training funds in FY 1990. We also urge your continued suport for the Biomedical Research Support Grant Program and other mechañisms to further the support of new investigators, innovative research projects and techniques, and multi-disciplinary research.

NATIONAL INSTITUTE ON AGING

The National Institute on Aging (NIA) is the major source of federal funding for behavioral, social, neuropsychological, and biomedical research in aging, and its mission is to improve the quality of life of Americans as they age. NIA-supported research is aimed at diminishing the physicial, psychological, and social problems often suffered by older Americans at great emotional and financial cost to these individuals and their families. Behavioral and neuropsychological research is conducted on adult cognitive development, sensory and perceptual mechanisms and processes, health attitudes and behavior, psychosocial functioning, and Alzheimer's disease and other types of dementia.

Foremost among the priorities for behavioral and social research at NIA is long-term care. The mounting demands for long-term care in our aging society, combined with the high societal and personal costs of such care, pose a pressing need to strengthen NIA's research in this area. The scientific groundwork has been laid for tests of social and behavioral interventions that could improve health, functioning, and independence in old age, but a continued commitment by the federal government is necessary if we are to keep pace with the rapid growth in new research opportunities in these and other areas. Yet while NIA has received much needed increases in funding in recent years, the Behavioral and Social Research program has nevertheless experienced a 30 percent drop in its ability to fund new projects. We thank this Committee for its past support of NIA, and urge further assistance in providing NIA with the support necessary to meet vital basic research needs related to aging.

Another research area ripe with opportunity for improving the quality of life of the elderly and their families is sleep disorders research. Disorders of sleep afflict over half of all people beyond the age of 65 who live in communities and about two-thirds of the elderly in chronic care facilities. Problems in nighttime sleep and daytime awakeness disrupt not only older persons' lives but also that of their families and caregivers. Further, people over 65 years of age now constitute about 11 percent of the American population but purchase an astonishing 25 percent of all prescription drugs sold in this country, as well as an unknown percentage of the over-the-counter medicines. A large proportion of these drugs are sleep medicines and hypnotic agents whose safety and efficaciousness have not been established in the aged. It is not known what are the risk-benefit aspects of these drugs in this population nor is it known to what extent they contribute to or alleviate the problems of sleep in the elderly. It is necessary to understand the causes of these disorders and to develop better treatment strategies, especially non-pharmacological methods, to correct these sleep disorders. In addition to affecting the quality of life, deviant sleep is also associated with excess mortality due to accidents. Additionally, since abnormal sleep in the elderly can reflect underlying disease states, further elucidation of the underlying mechanisms of sleep and their corrections is an important priority of the National Institute on Aging. We urge the Subcommittee to increase by 30 percent the $4.1 million FY 89 research support of this area in FY 90 and to raise the research commitment to 50 percent in FY 91 to take full advantage of research opportunities now available.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

NICHD is the major source of federal funding for research pertaining to maternal and child health and populations sciences. In particular, important behavioral research is underway in the NICHD Human Learning and Behavior Branch in the area of Acquired Immune Deficience Syndrome (AIDS). Although it is an area that has not received the visability of other AIDS research activities, continued attention to behavioral risk factors associated with adolescent experimentation is vital. It is essential that we understand how to prevent HIV transmission among youngsters before they initiate high risk activity either sexually or through substance abuse, particularly intravenous drugs.

To that end, we remain concerned about the fate of the proposed survey of health and sexual behavior under development in the NICHD Demographic and Behavioral Sciences Branch. This survey, the first comprehensive evaluation since the Kinsey Report over forty years ago, is essential to our effort to battle a number of critical health problems including sexually transmitted diseases, unwanted pregnancies, and AIDS. The survey will provide information as to the current sexual practices of the general population, the use of contraceptives, and the sexual behavior of at-risk populations for sexually transmitted diseases. Current projections for the number of AIDS cases are based on outdated and inaccurate data. The result is that both our prevention efforts and our projections for health care needs in this area may be seriously flawed. Virtually every scientific advisory group studying AIDS, including the Presidential Commission, have specifically called for current data of this nature. We urge the Committee to support this effort, and to direct the Department of Health and Human Services both to more forward quickly with the testing of the survey instrument without any substantive modifications that would affect the integrity of this vital project, and to provide for full funding of the survey as proposed in the President's FY 1990 budget.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

The National Academy of Sciences, the National Research Council and the President's Commission on the HIV Epidemic have all reported that one of our most pressing needs in AIDS research is more activity in the social and behavioral sciences. While all of the ADAMHA agencies have incorporated this mission into their work plan, the NIH has been less involved in meeting this pressing need. This is particularly true at the National Institute of Allergy and Infectious Diseases (NIAID), which receives most of the Public Health Service AIDS research budget. While we understand that NIAID's staff have indicated interest in working to enhance behavioral and social science research opportunities, the record reflects an absence of behavioral endpoints in NIAID-supported research.

A host of opportunities for behavioral research exist at NIAID and are critical to the success of the AIDS research mission, including research on: accrual and retention of specific populations (such as ethnic/minorities and women) into clinical trials of drugs and vaccines; measuring quality of life variables in assessing drug efficacy; patient adherence to treatment protocols; behavior change questions in longitudinal studies of patients; and ethical questions such as the duty to inform research subjects of their HIV status. We urge the Committee to direct NIAID to expand its AIDS research focus to include initiatives in the social and behavioral research arena.

NATIONAL CANCER INSTITUTE

We urge the Subcommittee to direct the National Cancer Institute (NCI) to dedicate a larger proportion of its budget to behavioral research, particularly in the area of cancer prevention. NCI indicated in its component of the NIH health and behavior report that smoking and tobacco use, diet and nutrition, and regular cancer screening, all behavioral factors, are critical to cancer control. Clearly increased attention to biobehavioral research and human behavior is an important step in order for NCI to meet its goal of reducing our Nation's annual cancer death rate by fifty percent by the year 2000.

NATIONAL HEART, LUNG AND BLOOD INSTITUTE

We recommend that the National Heart, Lung and Blood Institute (NHBLI) be directed to increase significantly its percentage of funds dedicated to behavioral research. Fifty-five percent of all deaths in 1986 are accounted for by cardiovascular, lung, and blood diseases. These diseases represent five of the ten leading causes of death, and are alone responsible for twenty-four percent of the total economic costs of all illnesses and premature deaths. Nowhere is the relationship between health and behavior clearer than in coronary, lung and blood diseases. NHLBI has done excellent work in this area, and we urge that an increased proportion of its funds be dedicated to its important behavioral research.

Thank you for the opportunity to offer our views.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association appreciates this opportunity to express its support of research, education, disease prevention, and data collection activities -- all of which depend on public funding for their continued effectiveness in improving the dental and general health of our citizens.

Dental Research: As the Association has noted in previous testimony, dental research is the foundation for the success of the dental profession to date in lowering the incidence of dental disease in the population and in reducing the national annual expenditure for dental care by approximately $2 billion.

Since 1948, when the Congress created the National Institute of Dental Research, it has become the nation's preeminent dental research center. NIDR has made great strides in exploring the causes of and most appropriate treatment for dental disorders.

In the past two decades, there has been a substantial drop in the prevalence of dental decay in the United States. In the single decade 1971 to 1980, the average number of decayed, missing, or filled teeth for children aged 5 to 17 plummeted from 7.25 to 4.77. In 1988, the Institute updated its earlier survey of children and reported that nearly 50% of children have never had a cavity, while the remaining children have fewer and smaller cavities than children surveyed in 1980.

This encouraging trend is directly attributable to NIDR's identification, a decade earlier, of the major components of the tooth decay process: a cariogenic diet, susceptible tooth surfaces, and the bacterium streptococcus mutans.

NIDR is now internationally recognized as the leader in new research into developmental biology, tissue formation and bone metabolism.

Its achievements in virology research related to diabetes and herpes simplex type 1 and 2 are widely acknowledged, as are its accomplishments in materials research which have redefined today's restorative dentistry.

The work of dental scientists in identifying early oral changes associated with AIDS contributes greatly to our understanding of the routes of this infection and the appropriate behaviors to prevent its spread. A component in saliva has been identified that inhibits the infectivity of the human immunodeficiency virus: a most encouraging discovery.

This research must continue and special emphasis is needed in these areas:

- The need to develop new diagnostic methods for early identification of those individuals susceptible to caries and periodontal diseases.
- The need for new approaches to prevent, repair and even reverse disease processes.
- The need to understand what happens to the oral tissues in relation to changes in immunity, in endocrine gland function, and in other body systems; and how oral health affects and is affected by systemic diseases common in old age.

In addition to the above examples of basic research, a need exists to initiate clinical research centers which would provide a step toward the transfer of dental technology from the laboratory to the practicing dentist and the general public. One of these centers should be devoted to temporomandibular disorders and their treatment.

The Association joins the American Association for Dental Research in urging the Committee to appropriate $171,900,000 to fund NIDR's most valuable activities in FY 1990.

Dental Education: In 1988, as a part of the Health Professions Training Act, the Congress broadened the Exceptional Financial Need (EFN) Scholarship Program to include students in all four years of health professions training.

Prior to that time, only first-year students qualified for EFN Scholarships. The Association is most appreciative of this expansion. But, if the potential of the revised EFN program is to be realized, a substantial increase in appropriations will be required.

The Association requests that this program be funded at the authorized level for FY 1990 of $30 million.

The significance of General Dentistry programs has grown in recent years, commensurate with intensified public interest in the health needs of our special populations, the frail elderly, the handicapped, and those afflicted with AIDS. Last year, because of the limited level of federal funding, one in three applicants for General Dentistry programs was turned away because of insufficient positions in the schools nationwide. To correct this, the Association recommends that $6 million be appropriated for FY 1990.

The activities of Geriatric Education Centers (GECs) include short-term faculty training, curriculum and other educational resource development, technical assistance and outreach.

The Association recommends that $10 million be appropriated for FY 1990 to allow continued support of GECs at the FY 1989 level.

Geriatric Training Programs provide one- and two-year postdoctoral fellowships for medical and dental faculty.

To initiate fellowships for approximately 150 academicians and researchers, the Association requests that $7 million be appropriated for FY 1990.

Disease Prevention: The Association is most appreciative of the Committee's recognition of the value of the Dental Disease Prevention Activity within the Centers for Disease Control.

Although DDPA's contributions to improved oral health of the American public have been significant, resource constraints since the responsibility was transferred to CDC have severely limited opportunities for additional accomplishments.

The Dental Disease Prevention Activity should be appropriated in FY 1990 $2,415,000 to develop and implement the full range of service to the public in oral health promotion and disease prevention, capitalizing upon existing state of the science and current oral health issues of public health significance.

Data Collection and Analysis: Further, the Association urges that $56 million be appropriated for the National Center for Health Statistics in order that it may continue to conduct statistically sound activities that embrace all major health sectors.

Comprehensive analysis of data collected by the Center regarding dental visits, preventive home care practices and public understanding of dental disease risk, as well as conduct of the third cycle of the National Health and Nutrition Examination Survey (NHANES III) which was inaugurated in 1988, is essential to a reasoned approach to dental health measurement.

The Association is gratified by the recent interest in dental health services research demonstrated by the National Center for Health Services Research. Accordingly, we recommend that NCHSR be funded at the FY89 level of $18.5 million and that $2 million of this amount be designated for dental health services research.

The Association also supports full funding of the President's request of $52 million for Patient Outcome and Medical Effectiveness Research, to be administered by NCHSR.

Research and Action Program on Oral Health Promotion for Adults: Finally, the Association commends to the Committee's attention the Research and Action Program on Oral Health Promotion for Adults. This new project is envisioned as a cooperative, coordinated initiative, involving basic foundation research, demonstration projects, and oral health promotion, all directed at increasing the oral health awareness of the adult population and improving this population's oral health status.

To begin this program in FY 1990, an appropriation of $654,400 is needed.

STATEMENT OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA

For the first time in several Congresses, the Infectious Diseases Society of America ("the Society") did not testify before the House and Senate Appropriations Subcommittees with NIH oversight. The Society therefore would like to take this opportunity to share with members of the subcommittees its views regarding Administration proposals for funding of the National Institute of Allergy and Infectious Diseases (NIAID).

I. Infectious Disease Specialists

The discipline of infectious diseases is a subspecialty of internal medicine and will soon become a subspecialty of pediatrics. Infectious disease specialists focus on the interaction of the patient's immune system and the various organisms (viruses, bacteria, fungi etc.) which cause infections. The immune system is critical to the health functioning of the human body because it provides the necessary protection against these external invaders, as well as against certain types of cancers. Without an immune system, we could not survive.

The Society is comprised of approximately 2,500 specialists in this field, including physicians involved in clinical and basic research in infectious diseases, as well as physicians who concentrate on clinical practice. Infectious disease specialists are the primary care physicians for patients suffering from AIDS, which attacks the entire body, not just a specific organ.

The Society has two major concerns with the Administration's budget request for NIAID for FY 1990: the continued attempts to consolidate funding for AIDS programs outside the specter of NIAID and inadequate funding for non-AIDS research.

II. Consolidated AIDS Account

In past years, the Labor-HHS Subcommittees have wisely rejected Office of Management and Budget proposals to restructure the means of appropriating funds for HHS efforts to eradicate AIDS. The budget request envisions the placement of all AIDS money in an account under the Office of the Assistant Secretary for Health (OASH). While central governmental oversight of federal AIDS activities is essential, adoption of this proposal will stifle ongoing and future research and training efforts.

Years of research and manpower are finally culminating in the development, testing and approval of drugs to treat deadly viruses associated with AIDS, prolonging and improving the quality of life for sufferers. The prospects of a cure and vaccine for AIDS are still a number of years in the offing. However, for individuals not yet exhibiting the disease's symptoms, HIV-positive tests will not render an automatic death sentence. One day, all people may look forward to a safe, effective vaccine against transmission of the AIDS virus.

However, time is of the essence. These dreams are possible only if funding is made available immediately when grant applications for research are approved. If the AIDS money intended for NIAID programs is placed in the OASH budget, *the ability to fund research efforts will be considerably slowed*. The Society anticipates that the extra layer of bureaucracy would result in several months' lag time from the point at which money is requested until it is released. When faced with a national epidemic, these months could prove to be crucial.

Moreover, the proposal places NIAID in an awkward position. *While the Institute will be overseeing extramural and* *intramural research on AIDS, the salaries of its scientists would be in the OASH budget.* This is contrary to good management principles.

The Society urges Congress to reject once again the Administration's proposal to consolidate the AIDS monies and allow NIAID to receive its due appropriation directly.

III. Non-AIDS Funding

Congressional support for NIH, albeit steadfast for the past several years, leaves the nation's non-AIDS biomedical and behavioral research effort threatened by the severity of the constraints on funds to support new investigators and new ideas. The Administration's budget request cuts 16 percent out of on-going budgets in order to fund AIDS-related research programs. This suggestion spells disaster for the scientific community as a whole.

In its Professional Judgment Budget (PJ) proposal for NIH funding for FY 1990, researchers and biomedical professionals recommend spending targets which are more limited in scale than those of the past two years because of the recognized need to restore funding for research project grants and research training. *The existing effort must be adequately funded before embarking on growth by recapturing at least a portion of the scientific momentum that has been generated during the past 20 years.* The recommended spending levels contained in the PJ budget are made with full awareness of the fiscal crisis confronting the nation. However, Congressional support of the National Institutes of Health is a high priority investment in the nation's future.

It is also worthy to note that NIH has extended the period of commitment of funds to research project grants. Over 50 percent of the research project grants awarded in 1988 were for five years, compared to approximately 20 percent in the mid-1980s. The benefit of these longer awards is that scientists are able to devote more time to the conduct of research rather than spend time preparing more frequent applications. Moreover, the stability created by these long-term commitments is essential to effective recruitment and retention of scientific personnel in the university setting.

However, the longer award period increases the amount of funding needed to support competing research project grants. It is imperative that NIH funding levels be adequate to maintain its commitments to the exciting and ground-breaking biomedical and behavioral research already under way.

Toward this ideal, the Society is particularly concerned that high priority clinical trials under the jurisdiction of the NIAID are ready to begin *but for which funds do not exist in the Administration's FY 1990 budget*. Among these are efficacy trials for vaccines to protect infants and children (as well as adults) against acellular pertussis (whooping cough), diarrheal diseases, influenza A, bacterial meningitis and related infections, and genital herpes. Also, trials for prophylactic therapy for neonatal herpes and treatment with ribavirin for chronic non-A, non-B hepatitis are urgently needed. Finally, studies regarding the management of childhood asthma in urban America, the incidence of which has been rising inexplicably over the past two decades, is necessary. For the convenience of the committee, attached to this testimony is a detailed summary of each of these projects, together with cost estimates, as prepared for the professional judgment budget.

IV. Concluding Recommendations

The Infectious Diseases Society of America believes that only through an increase in appropriations above the President's request can NIAID meet its stated goals for advances in research and training for infectious diseases, including AIDS. All funding, both for AIDS and non-AIDS programs, for NIAID programs should be allocated directly to NIAID for administration.

The infectious diseases community appreciates the consideration of House and Senate Appropriations Subcommittees on Labor-HHS for its recommendations and past support for NIH activities.

STATEMENT OF PAUL A. MARKS, M.D., PRESIDENT, MEMORIAL SLOAN-KETTERING CANCER CENTER

My name is Paul A. Marks. I am a physician and cell biologist whose primary research interest has been in the area of normal and cancer cell differentiation. Since 1980, I have been President and Chief Executive Officer of Memorial Sloan-Kettering Cancer Center. Prior to that I was Vice President for Health Sciences at Columbia University and Director of its Comprehensive Cancer Center. I have served as a member of the President's Biomedical Research Panel and the President's Cancer Panel. Recently, I chaired the National Academy of Sciences, Institute of Medicine Committee which produced the report on national resources for clinical investigation.

Mr. Chairman, I thank the Committee for the opportunity to testify before you on one of the most important funding issues on the nation's agenda. Since the end of World War II -- particularly since 1972 -- the role of the federal government has been absolutely critical to the rapid advances achieved in the basic understanding of the nature of cancer and in the improvements made in the control and cure of the disease. Today, however, we are facing substantial constraints on the future funding of cancer research and cancer centers, which is a matter of concern.

This is a time of unprecedented opportunities in cancer research: a time when the advances of the past decade are being translated into clinically useful and important drugs, devices, and procedures; a time when we are improving our ability to prevent cancer, and provide earlier and more accurate diagnosis; and a time when we are expanding our capabilities to devise more effective and definitive therapies. Taking action in these areas is our best hope to decrease the rapidly increasing costs in cancer treatment.

To seize upon these opportunities and bring further advances in cancer prevention and treatment to the people of our country, funding is needed in four major areas: First, continued support of basic research, in particular, investigator-initiated RO-1's (single investigator grants) and PO-1's (program project grants). It is estimated that the National Cancer Institute, in 1989, will fund less than one-third of all approved grants. This is too low to maintain a fruitful biomedical research enterprise in this country. We must aim to fund at least 40-45 percent of all approved grants. Second, we need to increase support for training scientists -- particularly clinical investigators. Third, we must fund clinical investigation to assure the necessary and appropriate translation of basic research to clinical application. And fourth, we need an organized agenda for treatment outcome research.

Comprehensive cancer centers have been a particularly effective means of providing the combined material resources for all of these goals. I can best illustrate this point by describing the Memorial Sloan-Kettering Cancer Center -- the oldest, largest, privately operated, nonprofit institution devoted to research, education and patient care in this country. The Center has two operating organizations -- the Memorial Hospital, a 565 bed facility with a large outpatient service; and the Sloan-Kettering Institute for Cancer Research. We have a clinical staff of 345 physicians, many of whom have a major commitment in clinical investigation. The Center's education programs provide research and clinical training at graduate and postgraduate levels. Our basic research spans a broad spectrum of biomedicine and is carried out under the leadership of 130 full-time members of our scientific staff. One of the hallmarks of Memorial Sloan-Kettering is the close collaboration between scientists at the bench and physicians at the bedside. Very importantly, the Center has a major commitment to the evaluation of alternative means of delivering patient care, such as our successful day hospital program, which provides an effective, less costly option to in-hospital care for patients requiring intensive chemotherapy.

Our total projected operating budget for 1989 is approximately $350 million, of which about $70 million is for research. Federal grants provide 65 percent of research support (the vast majority are RO-1 and PO-1 grants from NCI). Thirty percent of our research comes from foundations and private philanthropy. In recent years support from industry has increased; and it now represents about six percent of our research budget.

Basic Research

At Memorial Sloan-Kettering and in leading cancer centers across the country, we are attacking cancer in ways unimagined a decade ago. This in large part is due to the support of basic research. By its very nature, basic research is the pursuit of new knowledge whose course cannot be predicted and cannot be planned. The critical element in evaluating basic research is an individual scientist's imagination and creativity.

We can cite concrete examples where the translation of basic research is contributing to remarkable improvements in our ability to care for cancer patients. The product of years of fundamental studies on the regulation of cell function, growth and development have now been brought to the bedside. Clinical trials are underway to test new approaches to major problems confronting practicing oncologists. The successful use of chemotherapy for cancer has been limited by two factors: toxic side effects on normal cells and the development of resistance by tumor cells to the cell-killing properties of drugs.

Studies over several years at Memorial Sloan-Kettering and at other cancer centers have identified the hormone-like growth factors responsible for the production of blood cells. These factors, such as G-CSF -- which have now been produced in substantial quantities through recombinant DNA technology -- enable clinical investigators to deliver curative doses of chemotherapy and significantly reduce life-threatening infections that are costly to treat.

As a result of several years of laboratory studies, Memorial Sloan-Kettering investigators have made some of the most important observations documenting the genetic basis to certain forms of drug resistance. As a result of this work, methods are now being developed to circumvent resistance and thus improve the effectiveness of drug treatment.

In the area of my own research interests, over the past decade, my laboratory and several others have established that many cancer cells retain the potential for normal growth and that simple chemicals which are not cytotoxic agents can induce cancer cells to behave in a normal fashion. During this past year, a clinical trial using one such chemical which we discovered, namely, HMBA, provided preliminary evidence that this new approach to treat cancers may be useful. These are but three examples which point to the importance of continued support of basic research as our most promising approach to more effective control and cure of cancers.

Research Training

We need well-trained scientists -- particularly clinical investigators -- to exploit the opportunities that we have to translate the products of basic research into effective and less costly approaches to the care of patients with cancer. Financing of research training is a critical and very challenging problem today. The requirements for training clinical investigators are rigorous and a long period is needed, usually about 5 years, to achieve competence as productive and creative scientists. Our national training programs must produce approximately 1,000 new clinical investigators per year to replace the medical school faculty who are retiring from their careers in scientific investigation.

Clinical Investigation

A number of changes in health care reimbursement have taken place or are proposed which will lead to increasing the inadequate funding of clinical research. I am particularly concerned with the Medicare regulations that deny reimbursement for patient care costs in clinical trials with investigational drugs, even though these clinical trials may represent the best approach to the treatment of those cancer patients whose disease cannot be controlled or cured by established therapies.

The IOM Committee on Resources for Clinical Investigation, which I recently chaired, concluded that it is inappropriate for third party payers to deny reimbursement for all appropriate and necessary patient care costs that would have been incurred in any case simply because a patient is on an investigational protocol, excluding, of course, marginal costs owing to investigational intervention. Such policies could severely limit progress toward the development of the very interventions that will be more effective and less costly in patient care.

Approximately 50% of all patients whose cancers are diagnosed this year will have their disease controlled or cured. Now we must focus on those 50% whose cancer cannot be controlled or cured.

I am pleased to report that we have made important advances in the diagnosis and treatment of certain cancers:

Lung cancer -- One of the most devastating forms of the disease. Memorial Sloan-Kettering physicians have developed a new combination chemotherapy for use in inoperable non-small cell lung cancer. This new combination has produced major responses in 67 percent of patients, compared to a cure rate of only 43 percent in 1981.

Colorectal cancer -- At Memorial Sloan-Kettering, scientists and clinicians have pioneered in the development and transfer of new technologies that make it easier and less costly to diagnose and treat colorectal cancers. The development of the hemo-occult blood test has lead to earlier diagnosis and more definitive treatment. For treatment of colon cancers that have spread to the liver, the implantation of a pump that delivers chemotherapy directly to the liver has resulted in longer survival and substantially improved quality of life for patients whose tumors have spread beyond the curative approach of surgery.

Breast cancer -- Advances in mammography technology and wider use of this diagnostic technique have the ability to reduce breast cancer mortality in this country by 30 percent. This is also the most cost effective to deal with the problem of breast cancer - namely, to definitively treat the early disease.

Pediatric cancers -- Advances in pediatric cancers have been remarkable. Take, for example, children with acute lymphoblastic leukemia, chemotherapy now results in a cure rate of 70 to 80 percent.

Research on Treatment Outcome

We need to be able to better evaluate the options for disease prevention and treatment that are the products of clinical investigation -- to evaluate options for new clinical applications as well as "established" practices. The parameters of such evaluation include, but are not limited to, quality of care, treatment outcome, and costs. We need to develop research methodology, train investigators in this area of research, and provide feed-back programs for practicing clinicians and policy-makers. Cancer centers are ideal sites for conducting such research. At Memorial Sloan-Kettering, we have recently completed a study of the options for the delivery of intensive chemotherapy to determine optimal therapeutic effectiveness and most reasonable costs. And we recently began a study on the outcomes and costs of care for patients with advanced cancers.

In conclusion, I applaud the initiatives of the Committee in performing a careful review of our nation's biomedical research enterprise. I respectfully request your consideration of the following:

1) A reasonable rate of increase in federal funding of basic biomedical research, namely, RO-1's and PO-1's, to exploit the unprecedented opportunity for advancing our understanding of the causes of cancers and the approaches to effective prevention and cure.
2) An increase in support of training programs, particularly at cancer centers

where close interaction between basic laboratory research and clinical investigation provide an excellent environment for such individuals.

3) An increase in funding for clinical investigation -- including clinical trials -- and appropriate third party reimbursement for patients in such trials. A funding initiative in treatment outcome assessment research. Adequate funding of clinical investigation is essential if we are to realize that which is within our grasp, to prevent or cure many cancers not yet conquered.

4) Stabilization of the funding of cancer centers -- the nation's leading resource for research, training and patient care in cancer.

We have made a great deal of progress particularly over the past two or three decades. The translation of this progress to cancer prevention and cure has never been a more promising and exciting opportunity. We must place a very high priority in making sure we realize this opportunity.

STATEMENT OF BRUCE S. JACOBSON, PROFESSOR OF BIOCHEMISTRY, UNIVERSITY OF MASSACHUSETTS

I appreciate the opportunity to express my concern about the level of funding for the National Institutes of General Medical Sciences (NIGMS). I am a Professor of Biochemistry at the University of Massachusetts in Amherst spending most of time conducting basic biomedical research and teaching both undergraduate and graduate students. I have been funded by NIGMS beginning as a graduate student in the late 1960s and continuing as a Postdoctoral Fellow in the 70s, and as a Principal Investigator in the 80s (my attached Curriculum Vitae will give you the details). In the following statement I will try to make the case that without a significant increase in the funding for fundamental undifferentiated biomedical research we could lose the tremendous ground we have made in exploring and devising treatments for many human maladies, and in providing the basic concepts necessary to keep our biotechnology industry viable and competitive.

The tightness of funds for NIGMS becomes even more worrisome when one considers that new pathogens are evolving, and no doubt existing ones are lurking in outlying populations of humans or other animals, and if given the opportunity the pathogens will spread. The risk of spreading becomes even higher as populations grow and become more mobile. An example of this situation is AIDS. It should also be emphasized that in spite of the tremendous advances that have been made in understanding molecular genetics and the potential for gene replacement therapy, we must not be lulled into thinking that we are winning the war on genetic diseases. New mutations are always occuring and existing genetic abnormalities will begin to show up as our life expectancy increases. The above problems became more evident to me after I was made Director of a rare genetic disease foundation. It's called rare because it is only thought to involve between 20,000 and 40,000 people in the United States. I guess when you consider that there are about 4000 recognized genetic diseases, and more on the horizon, we're talking about a lot of suffering.

I am sure that in the course of your hearings you will be presented with specific examples of the irreplaceable role that NIGMS Grantees play in laying the foundation for research by the categorical institutes and biotechnology companies. Probably most of you have been on this committee for several years and have heard similar testimony in the past, and judging from the budgets you have recommended you understand the vital role of the training programs and the research that the NIGMS supports. Now I come to you and say it is not enough. Why? It's not enough for several reasons but because of the limitation of time, I will only discuss two that seem to me to be most currently critical.

One reason is that funding only a third of the research proposals when almost twice that many are worthy of funding creates a situation where many researchers become too risk aversive and are afraid to deviate from their original research plan and explore the unexpected result. It is the unexpected or the chance result that can lead to exciting new concepts. Unfortunately, we do not have the latitude to deviate from the original research plan since we run the risk of not being productive enough to be refunded. And experience tells us that productivity is most easily arrived at by generating results on the original research plan and publishing them in peer reviewed journals. So the unexpected result must be left behind. Aside from being demoralizing to the creative and inquisitive mind, a potentially more valuable discovery and breakthrough is not made. Put another way, if we doubled the number of investigator-initiated research grants my experience tells me that we would not only double the productivity but we would also enhance our chances of major breakthroughs.

The second reason that the recommended level of funding for NIGMS is inadequate is that it is not sufficient to attract talented new people, and in fact contributes to the loss of many who have their Doctorate to other professions or to industries not requiring the hassle and the insecurities associated with generating funds for investigator-initiated research. This latter aspect is most critical when one considers that many University faculty hired in the scientific and educational boom of the 50s and 60s will be retiring soon, and it would be tragic to have to fill the ranks with less than the best. We are finally at a time where we can replace many individuals who were not research oriented with those who are. However, I am afraid that if we do not create an atmosphere where students see that a life as a scientist is more than spending an inordinate amount of effort writing grant proposals or worrying about whether we are going to be funded and who is going to be laid off, we won't get the bright, creative minds we need. We must not be deprived of the tools to capture the minds and curiosity of our student apprentices both at the undergraduate and graduate levels. Of the five Ph.D. students I have advised only two have opted for University careers, one an Associate Professor at Rutgers and the other an Assistant Professor at Yale. Of the more than fifteen undergraduate senior honors and senior research students I have had in my laboratory, less than five will probably opt for careers in basic biomedical research. I should add that all of these undergraduates would have been accepted into most good graduate programs. In fact several have become physicians.

I would like to close by briefly chronicling my career to give you an idea of why I went into science. As a high school kid I was almost a failure. Being dyslexic during a time when learning disabilities were barely understood was not a good time for me. Fortunately, there were junior colleges that gave people like me a second chance. Most importantly, as a senior in a state University I was hired to wash glassware in a laboratory doing basic biological research. This was the turning point. I began to see the fun and excitement of using one's mind and was turned on. The principal investigator gave me the encouragement I needed to continue on for an advanced degree. To make a long story short, I have had my share of awards and withstood peer review for grants and publications. I have seen some of my basic research applied by biotechnologists and embraced by colleagues supported by the categorical institutes. I think I have come a long way since high school and I am sure there are many stories similar to mine. You might say I am one of the many foot solders in the research trenches who is beginning to wonder that everytime a grant is negotiated down, or a new one on which I have spent months working isn't funded, if the high command really appreciates what's going on.

Thank you for your attention.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association appreciates the opportunity to present its views on funding for the National Eye Institute (NEI).

The American Optometric Association is a professional association representing over 27,000 doctors of optometry, optometry students and educators across the nation. As a profession devoted to improving the vision care and health of the public, doctors of optometry diagnose, manage and treat conditions of the human eye and visual system.

Vision is our most highly developed sense. Vision is an essential part of everyday life, depended upon constantly by people of all ages: infants, children, adolescents, adults and older adults. Vision affects development, learning, communicating, working, health and the quality of life. Loss of vision is one of peoples' greatest fears.

Eye and vision disorders are major unrecognized public health problems. Poor vision affects the majority of the population causing disability, and loss of productivity. Poor vision is a significant risk factor for the health and performance of people at all ages. As our society's life expectancy continues to increase, poor vision becomes an increasingly serious handicap.

A large percentage of the U.S. population have poor vision and need periodic assessment and treatment. Approximately 50% of the population need eyeglasses to see clearly. Over 20% of children entering school have significant vision problems. Over 90% of adults over age 45 years require eye glasses. Almost 5% of the population has low vision and cannot be helped without advanced optical devices. These facts highlight the magnitude of the problem of vision disorders. Vision problems are one of the most prevalent health problems in the United States.

This testimony will focus on the following areas for increased funding in FY 1990: clinical research trials, individual investigator-initiated research grants, core grants, prevention education and low vision grants.

The American Optometric Association supports the goal of NEI to conduct research for treatment of eye disease, visual disorders, and the preservation of sight. We applaud the research achievements of NEI over the past 20 years.

Three years ago our association created the Council on Research in order to facilitate and assist in the coordination of optometric research. The Council has set research objectives and fostered cooperation within the optometric research community. One of the Council's specific goals is to promote clinical trial research. In June of 1988 the Council sponsored a four day clinical trial workshop to develop the expertise of optometric researchers. Since that time the Council has assisted in the development of several clinical trial proposals.

NEI has a remarkable record of scientific breakthroughs attributed to clinical trial research beginning with the Diabetic Retinopathy Study in the 1970s. Current NEI clinical trials involve many institutions, hundreds of health professionals and thousands of patients. These randomized, controlled trials will provide scientific verification of clinical techniques which can immediately be put into practice by eye care practitioners. We support the past emphasis placed on clinical trials by NEI and strongly urge the Committee to provide additional funding for future trials.

NEI's policy of support primarily of individual investigator-initiated competing research project grants is to be commended. We fully support this policy and urge the committee to approve an increase from the President's budget of $42.725 million and 258 grants to $73.086 million and 419 grants.

Individuals at risk for eye and vision problems frequently do not understand that there are preventive measures that can be taken. Comprehensive and regular eye examinations of patients of all ages are a vital part of any preventive effort.

Eye diseases such as glaucoma, and systemic diseases such as hypertension and diabetes, which have significant eye manifestations, cause serious and unnecessary loss of vision when not diagnosed early. Thus, we fully support the current National Eye Health Education Program funded in FY 89 in an effort to educate those at high risk for glaucoma and diabetic eye disease.

We urge the Committee to continue funding this education program which will initially emphasize the importance of early detection in preventing loss of sight from eye diseases.

Optometrists, the largest group of eye doctors, are concerned with the improvement, maintenance, protection and rehabilitation of vision. They provide primary, comprehensive and preventive eye care services to people of all ages. They are a major resource for managing vision disorders and for disease prevention and health education.

Rehabilitation is an important part of care for people with low vision not correctable with standard eye glasses. Currently, optometrists are involved in low vision research in a number of institutions funded by NEI. Optometrists are receiving low vision grants at the University of Alabama-Birmingham, College of Optometry; University of California-Berkeley, College of Optometry; Eye Research Institute, Boston; University of Houston, College of Optometry; and Pennsylvania College of Optometry, Philadelphia. More research is needed in this important area to help improve the quality of life and productivity of those individuals with low vision.

In order to prevent blindness and improve the quality of life of those with reduced vision we recommend an increase over the President's 1990 budget in the number of core grants from 27 to 36 at $12 million and individual training grants from 53 to 117 at $3.391 million. Furthermore, we request that the Committee recommend approval of $312 million for the 1990 NEI budget.

The American Optometric Association appreciates the opportunity to submit our views and urges the Committee to continue its strong support for vision research.

LETTER FROM FRANCIS MILLETT

Mr. Michael Hall
Professional Staff Member
Senate Appropriations Subcommittee on Labor--HHS
Room 186
Dirksen Senate Office Building
Washington, DC 20510

April 20, 1989

Dear Mr. Hall:

I am writing to offer public testimony to the Senate Appropriations Subcommittee regarding the Fiscal Year 1990 Appropriations for the National Institute of General Medical Sciences.

I am a University Professor of Chemistry and Biochemistry at the University of Arkansas. Support from NIGMS has been critical to the development of my entire research career in molecular biophysics, beginning as a graduate student in 1967 and continuing to the present. The award of a predoctoral NIGMS fellowship in 1967 made possible my Ph.D. training in NMR spectroscopy at

Columbia University. Likewise, a NIGMS fellowship supported my postdoctoral studies on the application of NMR to protein dynamics at the California Institute of Technology. I joined the faculty of the University of Arkansas in 1972, and received my first independent research grant from NIGMS in 1973, entitled "NMR Studies of Membrane Bound Proteins". This grant has been continuously funded from 1973 to the present, and is the major source of support for our research on electron transport and energy production in heart mitochondria. Furthermore, this grant has directly supported the training of over 20 predoctoral and postdoctoral students in biomedical research. I have gained additional knowledge of the important mission of NIGMS through service on a number of NIH review panels, and have been a member of the NIH Physical Biochemistry study section for the past four years.

The leadership position that the United States currently holds in biomedical research and biotechnology is due in large part to the support of basic research and training by the NIGMS. The mission of NIGMS is to support research on fundamental biological processes important to health. I would particularly like to emphasize the importance of investigator-initiated non-categorical research as a base upon which all disease-specific research and treatment rests. There are numerous examples in the files of NIGMS documenting how basic research has led to significant advances in the treatment of disease. The revolution that has occurred in genetic engineering as a result of NIGMS support is now leading to important new diagnostic and therapeutic techniques. Recombinant DNA technology has been used to produce tissue plasminogen activator for treatment of heart attack, as well as diagnostic probes for numerous genetic disorders such as Huntington's disease, cystic fibrosis, and muscular dystrophy.

NIGMS has also been at the forefront in the development of powerful new biophysical techniques to determine the structure and dynamics of proteins, nucleic acids, viruses, and biological membranes. One of the most exciting developments in my own field of bioenergetics was the determination of the complete X-ray crystal structure of the photosynthetic reaction center from the bacterium *Rb. sphaeroides* by George Feher and his colleagues at the University of California, San Diego. This historic achievment, supported by grants from NIGMS, provided fundamental new information on the precise pathway of electron transfer in a membrane protein. The techniques developed in this study should lead to important new information on how energy is produced and transformed in the mitochondrial membrane, and how the efficiency of this process is adversely affected by cardiac disease and muscular myopathies. NIGMS has also supported the development of nuclear magnetic resonance (NMR) into a powerful new technique for studying the detailed structure and dynamics of proteins and nucleic acids.

As the examples given above illustrate, NIGMS has played an essential role in the development of genetic engineering and molecular biophysics, two new disciplines that form the basis of our current leadership position in biotechnology. The emerging biotechnology industry is one of the most promising areas in the entire United States economy. The wisdom of supporting an adequate base of fundamental non-categorical research has been documented time and time again in terms of improved health care and increased economic competitiveness.

The Senate Appropriations Subcommittee has demonstrated an understanding of the need for adequate support of basic biomedical research and training over the years, for which all of us are grateful. However, I would like to discuss several concerns that have arisen because of the very tight budgets in recent years.

In my capacity as a member of the Physical Biochemistry Study section, I have had the opportunity to review nearly a thousand investigator-initiated NIGMS research proposals over the last four years. The most discouraging aspect of my service on this committee is to see the large number of excellent proposals from young investigators that were not funded because of inadequate support. The percentage of approved proposals that are funded has been dropping continuously over the past several years to the point where it is now approaching only 25%. At the same time, the quality of the proposals has been increasing, and a large fraction of proposals ranked excellent or very good have not been funded. I have seen young investigators resubmit proposals again and again, each time receiving a very good review, but with a priority rating just beyond the funding line. This has had a devastating effect on the careers of young investigators, many of whom depend entirely on NIH for their research support. Many qualified young investigators have decided to abandon their careers in biomedical research because of inadequate support levels.

The low funding levels have also had an adverse affect on the stability and continuity of research support for established investigators. It has become quite common for an established investigator with a very good to excellent priority rating to just miss the funding line for renewal. Even if the grant is renewed upon revision and resubmission, graduate students in the midst of thesis research may lose their support. This is extremely wasteful and discouraging to all concerned. I am particularly concerned about the possibility that the number of new and competing research grants will be curtailed, as this will exacerbate all of the problems mentioned above.

Finally, I am concerned that uncertainties in research grant funding are beginning to discourage our best students from pursuing a career in basic research. There are in fact significantly fewer graduate students and postdoctoral students now involved in basic biomedical research than there were 15 years ago. This comes at a time when the needs of the biotechnology industry are expanding rapidly, and a significant number of university faculty are nearing retirement. The shortage of trained personnel is becoming particularly acute in NMR spectroscopy, X-ray crystallography, and protein chemistry, areas of special interest to NIGMS. If continued, this trend will cause a significant loss of talent from our national biomedical research effort, with long-term consequences throughout the 1990's.

I request your help in securing adequate funds to allow NIGMS to continue its important mission to support basic research and training in the biomedical sciences. There is an urgent need to provide funds for a stable rate of growth in investigator-initiated research grants and training grants. Without this support, there is a real danger that the United States will lose the leadership position that it currently holds in biotechnology and biomedical research.

Sincerely yours,

Francis Millett

Francis Millett
University Professor

LETTER FROM GEORGE R. DEMUTH, M.D.

Michael Hall
Professional Staff Member
Senate Appropriations Subcommittee
on Labor--HHS
Room 186
Dirksen Senate Office Building
Washington, D. C. 20510

April 20, 1989

Re: Research Training and the
National Institutes of Health

Dear Mr. Hall:

I wish to present testimony on behalf of the Fiscal Year 1990 Appropriation about research training at the National Institutes of Health, with emphasis on the pre-doctoral (pre-Ph.D.) training funded through the National Institute of General Medical Sciences (NIGMS). I urge an increase in appropriation in order that the proportion of training to research funds be brought to better balance and the number of pre-doctoral training positions be increased to a level recommended by the National Academy of Sciences' ad-hoc committee and desirable for the future needs of our country.

The very nature of the NIGMS, evidenced by the word "General" in is title, means that it is committed to research and research training in the fundamental areas of bio-medical science. The research and the research training it sponsors are applicable to all of the Institutes, including the disease targeted ones. The NIGMS supported activities are often so fundamental and so pleuropotential that they may contribute to the base of every field of medical research. The enormous strides attained in the last decade in the bio-medical sciences reflect not only the support given during this period but also the foundation upon which they were built. These successful investigators are harvesting the fruits of the previous years. They are bringing to today's research skills and knowledge and ways of thinking from their training years before. Often that training was supported by the General Medical Sciences Institute.

The pre-doctoral research training deserves special concern. It is the most basic of this training and is, in time, most removed from the ultimate end-product of research. But it is essential. Our success today comes because of the investment in this training in the past. Such training now provides a heritage for the future.

The pre-doctoral trainees supported by the NIGMS are fewer in number than desired, fewer than recommended by the National Academy of Sciences' Committee on Personnel Needs by several hundred people, and fewer than will provide for the future research to the same extent it has in the past. It is a request to increase that number which is paramount in this statement.

In addition, a funding pattern which provides for the development of a plan and adherence to it over a longer period of time than one budget year is highly desirable; I do not know to what extent this is feasible or how much lies in the hands of the Congress.

As a Director of the Medical Scientist Training Program (MSTP) at the University of Michigan, I can testify to the extremely high quality of the scholars who are committed to this combined M.D.-Ph.D. training, which is very long, arduous, and demanding. As firmly as I believe in this training, I am convinced that it should exist in relation to established, strong pre-Ph.D. training programs. I appeal for support of both.

The Minority Access to Research Careers (MARC) program of the NIGMS is succeeding and is filling an important need. In the past five years I have watched its remarkable development and the impact it is having. Our MSTP training program has benefited by having its scholars join us. MARC is a program which should be zealously guarded and assisted in its further evolution.

Thank you for the opportunity to give testimony for the National Institutes of Health, in particular the National Institute of General Medical Sciences, and especially about the training programs within it.

Sincerely yours,

George R. DeMuth, M.D.
Director

STATEMENT OF BARRY SLEIGHT, CHRONIC FATIGUE SYNDROME INFORMATION INSTITUTE, INC.

Subject: The Need to Expand the Public Health Response to Chronic Fatigue Syndrome (Chronic Epstein-Barr Virus)

Mr. Chairman, I present this testimony as a patient with Chronic Fatigue Syndrome, or CFS, and also on behalf of nearly 300 patient support groups and

national organizations involved in matters related to this disease. This disease has also been known by other names, including Chronic Epstein-Barr Virus Syndrome (CEBV), and Chronic Fatigue Immune Dysfunction Syndrome (CFIDS)

The 1988 Labor-HHS-Education Appropriations Bill was accompanied by a report, number 100-399, which contained language with regard to this disease. The Committee urged the National Institutes of Health to expand research on this disease, urged the Social Security Administration to review disability issues related to CFS, and funded the Centers for Disease Control to continue small surveillance activity to suggest the national incidence of this disease. We offer the greatest of thanks to this Committee, and its able staff, for its leadership role in the Federal response to this disease.

The small surveillance program is beginning. It uses as a base the CDC-sponsored research Working Case Definition for Chronic Fatigue Syndrome that was issued in March 1988.

This definition includes many of the major symptoms that our patient population suffers with: severe fatigue, mild fever, sore throat, swollen and painful lymph nodes, muscle weakness and aches, fatigue after exercise, headaches, joint pain, sensitivity to light, spots in the field of vision, forgetfulness, excessive irritability, confusion, difficulty thinking, inability to concentrate, depression, and sleep disturbances. This definition is intentionally narrow for research purposes, and there are over twenty other symptoms listed in the medical literature for this disease.

Patients with CFS do have a wide variety of symptoms. The most severely disabled, an estimated 15-20%, are bedridden for an indeterminate period. It is these patients who are the most compelling in their suffering, and who are most likely to develop serious untoward outcomes from their illness. Biomedical researchers have been providing increasing information in areas related to CFS and are increasingly focusing on these untoward outcomes. I will illustrate the urgent need for a greater public health response to this disease problem by noting some of this research information.

In two groups of CFS patients, apparent higher rates of cancers, includin deaths, have been documented.

Abnormal muscle metabolism and structure have been documented in CFS.

Numerous reports in the medical literature have documented a variety of measurable neurological and cognitive function deficits and brain irregularities, as well as mental confusion, memory loss, difficulty concentrating, and depression in patients with CFS. Some of these irregularities are very similar to those found in patients with multiple sclerosis or AIDS.

Serious eye diseases, multifocal choroiditis and uveitis, have been documented in patients with CFS.

Biomedical research continues to document that CFS is a disease which involves the immune system. A number of medical articles have reported immunologic irregularities and associated metabolic defects in CFS patients. Irregularities, some of them profound, in the immune system components of B-cells, T-cells, interleukins, interferons, and Natural Killer (NK) cells have been reported. One subset of the NK-cells is nearly absent in some CFS patients. These cells are one of the body's first lines of defense against cancer; when there is a defect here, there is increased risk of cancer.

In recent years a number of agents, as well as some genetic predisposition, have been suggested by biomedical researchers as being possibly being involved in some way in CFS including:

Epstein-Barr virus, though the Director of the NIAID has recently testified at the Congress that the connection to this virus is "weak at best";

Human Herpesvirus 6 (HHV-6), also known as HBLV;

toxic exposure;

cytomegalovirus;

an adenovirus;

Rubella virus strain RA27/3, from the new, more powerful rubella live virus vaccine introduced into the U. S. in 1979; and,

several enteroviruses.

The director of the NIAID has reported to the Congress that "it seems likely that CFS is triggered by an infectious agent, probably a virus, which grows in lymphoid tissue and results in immune dysfunction" and that "immunological abnormalities can be the direct result of viral destruction of lymphoid cells, with the result dependent upon the subset of cells preferentially infected by the virus and the immunogenetic constitution of the infected individual." The director of the CDC has similarly reported that CFS involves "immunologic abnormalities, such as specific antibody or natural killer cell deficiencies." It has been proposed in the medical literature that a retrovirus, of that class of viruses that includes the AIDS virus, may be involved in at least some cases of Chronic Fatigue Syndrome. Recently two separate private-sector research groups, one in New Zealand and one in the United States, have identified viruses containing retroviral genetic material, similar in type to that found in the AIDS virus, in some patients with CFS, and are now classifying these viruses. The summary of current biomedical research is that at least some cases of CFS represent a serious acquired immune dysfunction disorder.

America is paying social and economic costs of this disease as lost jobs, broken homes, bankruptcies, and increased health and disability costs.

A typical pattern is one in which a person becomes sick with CFS, is quickly fired from work or forced to resign, and then has no health or disability insurance at a time of medical expenses that may run into thousands of dollars. The pain of financial devastation adds to that of the illness.

Patients continue to encounter a variety of difficulties in obtaining approval for Social Security disability benefits.

During the past year there has been increasing public health and legislative attention focused on this disease problem. The largest medical conference ever on this disease was conducted by public health officials in Sa Francisco one month ago; one of the stated purposes of this Conference was to explore whether "CFS is connected to AIDS." A CDC document related to this Conference called CFS an "emerging epidemic." The San Francisco Health Commission designated CFS a top health priority for 1989. Public health officials in Rhode Island held a large CFS conference in October. The NIAID held a small CFS research workshop in September in Pittsburgh. A pending bill in the Nevada Senate would make CFS a reportable disease, and CFS legislation is pending in both the California and Minnesota legislatures.

As I reported to this Committee last year, public interest in this disease continues to be very great. For example, some CDC operations have been disrupted by handling the large volume of inquiries, about 4,000 in FY88, related to this disease, and the NIAID Office of Communications reports that public inquiries about CFS are second only to AIDS.

While there is as yet no government data on the incidence of Chronic Fatigue Syndrome, several medical journal articles and numerous reports in the popular media suggest that this disease is concentrated in certain geographic areas around the country, that certain groups have a higher incidence, and tha CFS has increased in incidence dramatically since the early 1970s. The result of a European prospective study on CFS, if applied to the U. S., suggest that well over two million Americans may be falling victim to this disease.

The Federal response to CFS has been most welcome, but should be dramatically increased to meet the challenge posed by this disease.

We are concerned that the activities of the Public Health Service regarding CFS continue to be less than is consistent with a new epidemic of a disease of the immune system. The NIAID has a small intramural program involving CFS, but currently funds only one extramural research grant directly related to CFS. The only major activities of the CDC in this Fiscal Year related to CFS are both small and at the specific direction of the Congress.

We offer recommendations to the Congress to improve activities related to CFS, as follows:

--- To increase biomedical research into CFS, the National Institutes of Health should be directed to designate a senior official within the Office of the Director to coordinate NIH activities concerning CFS, to report to Congres on an annual basis about CFS activities, to use a variety of CFS grants solicitations types, and to designate a regional center for CFS research in th areas of greatest concentration of CFS. The NIH should be urged to conduct CF research in all institutes involved in AIDS research, and, to increase utilization of the wide range of CFS research performed in other countries, us the facilities of the Fogarty International Center for CFS research.

--- The Centers for Disease Control should be directed to continue and expand its CFS surveillance and epidemiology activities and accompanying research related to CFS. The CDC should be urged to study the possible roles of retroviruses, herpesviruses, and toxic exposures in CFS, to refine the Case Definition of CFS, and to standardize immunologic and psychometric testing in CFS. The CDC should be funded with 12 FTEs plus $15,000,000 earmarked for laboratory equipment, surveillance, epidemiology, research, and staff support to continue this work. To handle the enormous demand for information about this disease, the CDC should be funded with $500,000 earmarked for public information about CFS and $200,000 earmarked for education and training among health workers about CFS.

--- To continue and expand its research on CFS, the NIAID should be directed to expand its extramural activities to areas of greatest concentration of CFS and should be earmarked $10,000,000. The NIAID should be strongly urged to cooperate with the National Cancer Institute in basic CFS research; to develop specific assays, a reagent bank, gene sequencing techniques, and model clinica care protocols related to CFS; to conduct CFS symposia; to facilitate data exchange among CFS researchers; to develop state and community-based CFS clinical research opportunities; and to fund at least 50% of approved CFS research grant applications.

The interest and efforts of the Congress have had a significant impact on better understanding CFS; we ask an increase in these efforts toward the time when America is rid of this disease.

STATEMENT OF THE RENAL PHYSICIANS ASSOCIATION

Congress made a commendable commitment in 1972 to pay for the costs of treating all individuals with irreversible kidney failure under Medicare's End Stage Renal Disease (ESRD) program. However, this decision has had far-reaching budgetary implications. In 1987, the treatment of over 130 thousand end stage renal disease patients — including dialysis, kidney transplants and other treatments — cost the nation approximately $3 billion. Further, the number of individuals in need of these life-saving, but costly treatments is increasing: for example, virtually all individuals with insulin-dependent diabetes develop kidney failure after 22 to 30 years. Policy-makers are thus faced with having to make difficult decisions about the allocation of scarce resources.

In contrast to the above cost figures, only $111 million of our trillion dollar federal budget was spent on research on kidney disease in 1987. Obviously, the current relationship between costs of treatment and our federal research investment to reduce the incidence — and costs — of kidney disease is askew. RPA believes that the best approach to this problem is to increase federal investment in efforts which could lead to alleviating the high economic burden kidney diseases place on this nation, through accelerated research on improved treatments for, and prevention of, kidney disease. For this reason, we advocate increased funding for kidney disease research supported by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). At least $667 million will be needed to adequately support the programs of this Institute in FY 1990.

The Renal Physicians Association, (RPA), is a national professional organization of nephrologists. Our goals are to ensure optimum care for patients with renal disease and related disorders, to serve as a resource in the development of national health policy concerning renal disease, and to serve as a national representative for physicians who are engaged in the study and management of patients with renal disease. As practicing nephrologists, RPA members are involved in the day to day care and management of patients with renal disease and related disorders. For this very reason we have a unique perspective on research on kidney disease, especially with regard to practical applications of research advances to patient care.

KIDNEY RESEARCH: SUCCESSES AND OPPORTUNITIES

The NIDDK stands out as an institute which has had many successes result from research it has supported. This subcommittee has already heard about successes in the area of genetics research among the components of the NIH. NIDDK has been at the forefront in this area: for example, NIDDK-sponsored scientists identified the approximate location of the gene responsible for one form of polycystic kidney disease — a major cause of kidney failure. Then, just recently, they discovered that the other form of the disease appears to be caused by mutation in a nearby gene. These advances will enable clinicians to diagnose these diseases more effectively, and to develop treatments once the genes are identified precisely. Investigators are also now very close to identifying the gene defect responsible for Alport's syndrome, a hereditary disease of the kidney.

The number of ESRD patients whose renal disease results from complications of diabetes has steadily and sharply increased in just the last decade. Thirty percent of the new entrants in Medicare's ESRD program have kidney failure as a result of diabetes. Because the cause of kidney failure as a complication of diabetes is so poorly understood this is an especially pressing public health problem. NIDDK is moving forward rapidly with animal studies and other laboratory research to understand the mechanisms responsible for this disease. Animal research is now yielding exciting information regarding control of kidney disease in diabetic animals. This research has major implications for our understanding of diabetic neuropathy in humans. However, additional studies — including ones on potential drug therapies — are urgently needed in order to one day be able to conquer this severe and costly consequence of diabetes. Another category of diseases which contributes to the incidence of chronic renal failure are autoimmune diseases, (for example the devastating disease called lupus) which cause an inflammatory response which injures the structure of the kidney. Right now, drugs can be used to prevent and treat this inflammatory response, but more needs to be done to refine these approaches.

For kidney transplant patients, one type of infection (cytomegalovirus) is particularly problematic, especially because it often leads to other complications such as hepatitis. Patients who had received transplants from donors who had tested positive for the virus were treated with concentrated antibody to the virus in a recent NIDDK sponsored study. The patients receiving the treatment had 60 percent fewer cytomegalovirus-associated illnesses than those who did not, pointing to the value of this approach in preventing potentially serious illnesses in renal transplant recipients.

A great many additional research opportunities are still untapped. These research opportunities carry the potential for development of treatments and cures for many debilitating and life-threatening diseases. As the members of this subcommittee are too well aware, such progress is contingent on adequate financial support, and this is the reason we have come before you today.

OPPORTUNITIES IN TROUBLE

In light of these and other successes, and especially in light of the high toll kidney diseases take — in economic terms as well as in costs of human suffering — the RPA feels that the case for increased funding for kidney disease research is strong. However, we are concerned about federal funding for kidney disease research in FY 90.

Impact of MDRD Study:

As an organization representing largely practicing physicians, RPA is uniquely concerned about clinical research—the integral mechanism for transfer of basic research to the bedside. The Modification of Diet in Renal Disease (MDRD) study is one example of an important but expensive study which is being conducted in order to translate basic research into clinical reality. Yet if we had one point to make today, it would be our concern that, as it is presently being carried out, the MDRD trial is crippling kidney disease research conducted through the traditional investigator-initiated research grants. The conduct of the MDRD study will cost about $8 million during each year of its full scale phase, and this cost severely impacts the funding of the division's research grants. For the current fiscal year, the Division of Kidney and Urologic and Hematologic diseases (the section in which research is affected by the conduct of the study) will fund grants through the 20th percentile, while other divisions within NIDDK will fund at the 25th percentile.

We want to stress that this detrimental impact is not limited to the period of the conduct of the MDRD study. First, the MDRD is just one example; opportunities will continue to arise which allow us to better understand the risk factors and other underlying mechanisms leading to the progression of renal disease. If corrective action is not taken now, the same negative effects may occur again when another large study is undertaken. Secondly, biomedical research is cumulative by nature: when research opportunities are lost as a result of an insufficient amount of high-quality research grants being funded, the results of that research are lost as well as the results of any new research ideas which could have been built upon that research.

The RPA feels that a funding situation in which the conduct of a necessary clinical trial jeopardizes RO1 funding is untenable, and we believe that separate funding for clinical trials and epidemiological studies, aside from RO1 funding, is critical to the health of NIDDK's research enterprise. To correct the current situation, the RPA strongly supports an infusion of at least $4 million for FY 90 specifically to bring support of investigator-initiated research grants within the division of Kidney and Urologic and Hematologic diseases up to a more appropriate level. We urge the committee to do all that is within its power to see that this necessary add-on is provided.

O'Brien Centers:

The RPA believes that the George O'Brien Kidney and Urology research centers represent a big step forward in our national effort to address several very serious and very costly health problems. However, these centers are now supported at only two-thirds of the level originally envisioned by Congress. It is very unfortunate that these centers have not been provided with sufficient funds to fully carry out their mission. The RPA supports an add-on of $3.5 million for FY 90 which is needed to fully support the six existing George O'Brien kidney and urology centers, so that their original purpose can be realized. However, it is critical that this be provided in addition to, not at the expense of, increased support for investigator-initiated research grants. The RPA believes that the expansion of the centers program from six to twelve centers would be in this nation's best interest, as well. We urge the committee to take whatever steps are possible to fully fund existing centers, and to move toward an increase in the number of centers as an important complement to strengthened support of kidney and urology research project grants.

USRDS and health services research:

The End Stage Renal Disease Registry was mandated by Congress in 1986 in order to facilitate the collection and analysis of data on the distribution, causes, and treatments of end stage renal disease. The registry is to assemble and analyze data reported by the network organizations, transplant centers, and other sources which will generate useful scientific and economic analyses. This program has the full support of the RPA. The establishment of the United States Renal Data System, (USRDS) is now taking place at NIDDK. RPA is pleased with the institute's efforts thus far, and is optimistic that this program will ultimately be implemented in a way which will allow us to:

- identify the cost effectiveness and medical efficacy of alternative treatments;
- evaluate the most appropriate allocation of resources for treatment of ESRD and research on its causes;
- assess patient mortality and morbidity rates and trends on such rates, and other indices of quality of care.

RPA urges the Congress' continued interest in the optimal functioning of this important program. It is essential that sharing of ESRD demographic and treatment information be fully integrated by NIH and HCFA. Sufficient funds must be provided if data-sharing activities are to take place in a manner which will generate useful information rather than waste the resources which are currently being expended. We urge Congress to consider providing increased funding directed specifically toward support of "a coordinated, integrated approach to data collection and analysis".

The results of analyses made possible through the USRDS will be of critical value to the Congress as it makes determinations on ESRD funding policies. Furthermore, such analyses will provide essential information on which our on-going efforts to improve the management and quality of ESRD treatment programs can be based. For this reason, Congress should pay close attention to how adequately the program addresses the entirety of the Congressional mandate which created the registry.

The RPA also feels that more emphasis should be placed on research which, like the USRDS — addresses issues affecting the organization and delivery of medical care through analysis of socio-economic and scientific data. We would like to take a moment to explain about our interest in what is loosely referred to as "health services research". This area includes research on clinical practice (including descriptive research and the development of clinical strategies) and clinical epidemiology. We are concerned that there is not enough federally supported research in these clinical/applied areas, compared to basic research. In light of the vulnerability of the ESRD program — because of the scarcity of resources and the resulting interest in assessing (and making decisions affecting) quality of care — we believe that increased health services research must be conducted. Whether this will be conducted within the NIDDK or elsewhere at NIH, or (more likely) through some other part of the Public Health Service, we commend this important area to the committee's attention.

General Budgetary Concerns:

Overall, the RPA has significant concerns about the current level of our national commitment to biomedical research, and particularly about insufficient support of kidney disease research — in light of the high costs of kidney diseases to the federal government (through Medicare's ESRD program) and to society at large. As a whole, NIDDK supported over 30% of research grants approved for funding by study sections in the current fiscal year. Under the Administration's request for FY 90, it will be able to fund only about 23%. Among competing research grants, only 420 can be supported under the Administration's plan for FY 90, compared to 562 in the current fiscal year (a loss of 142 grants). This represents a one-quarter reduction in the number of competing grants at the NIDDK. This is particularly troubling because these are grant applications based on new ideas from promising investigators which are being lost. The idea of having a roughly 1 in 4 chance of having an approved grant funded (and even then having to anticipate a 10% reduction in funding) cannot be very encouraging for young investigators. In fact, RPA believes that the funding situation of the past several years is likely to turn bright young people away from careers in academic research. The RPA believes that efforts to encourage the best people to begin and continue careers in renal disease research should be a national priority. We believe that Congress must act to generate a federal research environment which encourages, not discourages, careers in academia and in research.

CONCLUSION

The RPA urges the committee to do all that is possible to ensure funding of at least $667 million for NIDDK for FY 90. This amount is needed to adequately support the vital elements within the NIDDK's research mandate, which we have described in this testimony. Though it is not enough to support all the scientifically valuable research which is available within the purview of the NIDDK, it is enough to begin to address the research funding shortfalls we have seen over the last several years. It is nice to know that there is a fiscally responsible avenue available to address the escalating problem of the high costs—to the government, and to society at large — of kidney diseases. That avenue is research. RPA strongly believes that we should capitalize on the opportunity to reduce our nation's economic burden by accelerating kidney disease research. Kidney disease research is essential; it is cost-effective in terms of opening up avenues toward improved treatments and better management of today's increasing pool of patients with kidney diseases, and it is absolutely necessary if we are to reduce human pain and suffering attributable to these diseases. We urge your commitment, through increased funding for FY 90, to kidney disease research.

STATEMENT OF BARRY GOLDRING

MY NAME IS BARRY GOLDRING. I AM 41 YEARS OLD. I HAVE A WIFE, 2 BEAUTIFUL SONS, AND A SUCCESSFUL BUSINESS. I ALSO HAVE HUNTINGTON'S DISEASE.

I WANT TO TAKE THIS OPPORTUNITY TO THANK YOU FOR ALLOWING ME TO MEET WITH YOU TODAY. THE FEW MOMENTS WE WILL BE ABLE TO SPEND TOGETHER WILL GIVE ME A CHANCE TO ENLIGHTEN AND EDUCATE YOU ABOUT A CURRENT ISSUE WHICH AFFECTS MY LIFE, THE LIVES OF MY CHILDREN, AND THE LIVES OF 25,000 OTHER PEOPLE IN THE UNITED STATES WHO HAVE ALSO BEEN DIAGNOSED. ANOTHER 125,000 PEOPLE ARE AT RISK.

THIS ILLNESS KNOWS NO BOUNDS. IT IS A NEUROLOGICAL DISORDER THAT SLOWLY AND SYMPTOMATICALLY DESTROYS THE BRAIN'S ABILITY TO FUNCTION NORMALLY. IT IS A SLOW DEGENERATIVE PROCESS TAKING YEARS TO DESTROY THE INFLICTED BODY AND MIND....AND HIS OR HER FAMILY AS WELL. EACH CHILD OF A PERSON DIAGNOSED AS HAVING HUNTINGTON'S DISEASE HAS AN INDEPENDENT 50% CHANCE OF GETTING THE DISEASE. YOU MAY REMEMBER IT BEST ...OR ONLY ... AS THE CAUSE OF DEATH OF WOODY GUTHRIE, ONE OF AMERICA'S TRUE FOLK HEROES.

MY FATHER DIED AT AGE 62 FROM A COMMON SIDE EFFECT OF HUNTINGTON'S DISEASE...HE CHOKED ON HIS FOOD. AT THE END OF HIS LIFE HE WAS CONFINED TO A NURSING HOME AND HIS DEATH WAS A TRUE BLESSING IN DISGUISE. THE DOCTOR'S ORIGINAL DIAGNOSIS OF HIS PROBLEM WAS THAT OF A "PROGRESSIVE NEUROLOGICAL DISABILITY OF UNKNOWN ORIGIN". I WAS ABLE TO NOTICE HIS PHYSICAL AND MENTAL DETERIORATION OVER THE NEXT FEW YEARS BUT HE WOULD NOT ACCEPT MY CONTINUAL PLEAS FOR HELP. ABOUT 5 YEARS AFTER MY FATHER'S ORIGINAL DIAGNOSIS, HE ONCE AGAIN RETURNED TO HIS DOCTOR WHO NOW SUGGESTED HUNTINGTON'S AS A POSSIBILITY. IT WAS AT THIS TIME THAT MY WIFE AND I WERE CAUTIONED ABOUT HAVING OUR OWN CHILDREN BECAUSE OF THE FUTURE WE WERE ABOUT TO GIVE THEM. NEITHER MY WIFE NOR I HAD EVER HEARD OF HUNTINGTON'S DISEASE. AFTER NUMEROUS PHONE CALLS AND INQUIRIES, WE WERE FORTUNATE TO BE ABLE TO ARRANGE A MEETING WITH MARJORIE GUTHRIE, WIFE OF WOODY, WHO AT THAT TIME HEADED THE COMMITTEE TO COMBAT HUNTINGTON'S DISEASE. SHE TOLD US ABOUT WOODY'S MEDICAL HISTORY, AND THAT BEFORE HIS DIAGNOSIS AND EVENTUAL DEATH, THE ILLNESS WAS SO RARE AND HIDDEN, IT WAS OFTEN MISTAKEN FOR SCHIZOPHRENIA OR EVEN ACUTE ALCOHOLISM. SHE ADDED THAT THE ONLY WAY TO TELL FOR SURE THAT A PERSON HAD HUNTINGTON'S DISEASE WAS TO PERFORM A SPECIAL AUTOPSY ON THE BRAIN AFTER DEATH BY NEUROPATHOLOGISTS. MY FATHER'S BRAIN SHOWED NO ATROPHY IN THE MIDSECTION WHICH MARJORIE GUTHRIE SAID WAS NECESSARY FOR A POSITIVE DIAGNOSIS OF THE DISEASE AT DEATH. I THOUGHT FOR THE PAST NINE YEARS THAT MY FATHER'S ILLNESS WAS SOME UNEXPLAINED PHENOMENA, AND AS LONG AS NO HUNTINGTON'S WAS POSITIVELY IDENTIFIED THAT I WAS SPARED THE DISEASE ALONG WITH MY PROGENY.

I WAS DIAGNOSED WITH HUNTINGTON'S DISEASE IN JULY 1988. MY FIRST DOCTOR, WHO IS THE HEAD OF THE DEPARTMENT OF NEUROLOGY AT THE UNIVERSITY OF MIAMI, SAID "GO HOME AND DIE. THERE IS NOTHING THAT CAN BE DONE FOR YOU." THE SECOND DOCTOR CONCURRED WITH THE FIRST'S DIAGNOSIS BUT DID PRESCRIBE A DRUG CALLED HALADOL, TO TREAT THE INVOLUNTARY MOVEMENTS CAUSED BY HUNTINGTON'S. THE

ONLY THING HE FORGOT TO DO WAS TO WARN ME ABOUT THE "NIGHTMARISH" SIDE EFFECTS OF THIS DRUG...DEPRESSION, LOSS OF SLEEP, AND IN SOME CASES INCREASED INVOLUNTARY BODY MOVEMENTS!

SINCE MY DIAGNOSIS IN JULY 1988, I HAVE WORKED FEVERISHLY TO LEARN AS MUCH AS POSSIBLE ABOUT THE DISEASE AND HOW TO ERADICATE IT. I HAVE CROSSED THE UNITED STATES LOOKING FOR THEE BEST DIAGNOSTICIANS AND TREATMENT CENTERS AVAILABLE (THERE ARE FEW)! THE DOCTORS AND STAFF PEOPLE I HAVE MET ALONG THE WAY, SUCH AS DR. ANNE B. YOUNG, M.D., Ph.D., THE UNIVERSITY OF MICHIGAN, AND DR. SUSAN E. FOLSTEIN, M.D., JOHN HOPKINS UNIVERSITY, ARE CURRENTLY WORKING ON A CURE. I BEGAN TAKING AN EXPERIMENTAL DRUG IN JANUARY OF THIS YEAR WHILE UNDER THE SUPERVISION OF DR. FOLSTEIN. I AM PART OF A BLIND STUDY, THE PURPOSE OF WHICH IS TO FIND A DRUG THAT WILL STOP HUNTINGTON'S DISEASE IN ITS TRACKS.

DR. JAMES GUSELLA OF HARVARD AND OTHER SCIENTISTS ACROSS THE WORLD ARE TRYING TO LOCATE THE HUNTINGTON DISEASE GENE. THEY BEGAN WORKING ON THIS PROJECT IN 1983 AND, ALTHOUGH THEY HAVE NOT BEEN ENTIRELY SUCCESSFUL, THEY ARE GETTING CLOSER. WHEN THIS GENE IS POSITIVELY IDENTIFIED, SCIENTISTS WILL BE ABLE TO CLONE THE DEFECTIVE GENE AND REPLACE IT.

ALTHOUGH GREAT STRIDES HAVE BEEN MADE IN RESEARCH AND TESTING, WE STILL HAVE A LONG WAY TO GO. AS WITH ANY GREAT DISCOVERY, THIS NOT ONLY TAKES TIME AND GREAT TALENT, BUT DOLLARS. DOLLARS TO STUDY, DOLLARS TO TEST, DOLLARS TO EXPERIMENT WITH. IT IS FOR THIS REASON THAT I COME TO YOU TODAY. HERE US AND HELP US. FOR WHEN WE FIND A CURE FOR HUNTINGTON'S DISEASE, WE FIND A CURE FOR MANY OTHER NEUROLOGICAL ILLNESSES AS WELL.

THANK YOU IN ADVANCE FOR YOUR SUPPORT. IT HAS INDEED BEEN AN HONOR AND A PRIVLEDGE FOR ME TO APPEAR BEFORE YOU TODAY.

STATEMENT OF KAREN ANTMAN, M.D., AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Mr. Chairman, I am Karen Antman, M.D., an Associate Professor at the Dana-Farber Cancer Institute and Harvard Medical School in Boston, Massachusetts. testifying today on behalf of the American Society of Clinical Oncology (ASCO).

The American Society of Oncology, founded 20 years ago, is the largest organization of physicians and scientists specializing in cancer, including prevention, treatment, teaching and research. Its members include the nation's leading physicians in medical and pediatric oncology, radiation therapy, surgical and gynecologic oncology, and also basic scientists in pathology, immunology, pharmacology, biostatistics, and other basic biomedical sciences, in literally all of the nation's medical schools, cancer hospitals, centers and institutes.

First, Mr. Chairman, ASCO would like to thank you and your committee for your continued strong support for both the National Cancer Institute and the National Institutes of Health in the past, and particularly last year. Your support is particularly noteworthy in this era of budgetary restraint. We are deeply grateful.

RECOMMENDATIONS ON APPROPRIATION LEVELS

Mr. Chairman, we strongly support for the National Cancer Institute (NCI) a funding level of $2.180 billion, with an additional $155 million for AIDS research in the NCI, i.e., a total of $2.195 billion. This is the so-called "By-Pass Budget Request" prepared according to the National Cancer Act of 1971 (as amended) authorization requirements. However, as we understand the budget constraints under which this committee is working, if your committee cannot fund at this level we would indicate that at least the level of funding recommended by the National Coalition for Cancer Research be granted.

In a recent survey of our members, the number one priority stressed repeatedly was funding for clinical trials. Virtually all clinical trials are conducted in cancer centers and in the cooperative clinical research groups. Thus, we support the By-Pass Budget call for an increase of funding for cancer centers. Although the By-Pass Budget requests the initiation of five new centers in 1990, it is our belief that the cancer centers currently in place should be funded at full peer reviewed levels, and a sufficient amount of funding should be made available to prevent the loss of cancer centers which otherwise would have their grant proposals renewed if there were sufficient funding.

Furthermore, we support the By-Pass Budget's increase of $20.8 million for clinical cooperative groups, which would assist in doubling patient accrual into clinical trials by 1992.

We also support an increase of $15.9 million for training to support 1,800 trainees through the National Research Service Award Program. (This committee is well aware of the problems introduced by the increase in stipend awards in fiscal year 1989. We fully understand that this committee was not responsible for the transfer of funding into stipends, and in fact could do nothing to deal with that issue in fiscal year 1989.) The By-Pass Budget would also provide $221.4 million for research grants which would fund 50% of approved competing research project grants at recommended levels. Of particular concern is the rapid decline in the number of competing research projects (R01's, P01's, etc.), excluding AIDS, as shown in the table below.

FY Year	Number
1985 Actual	999
1986 Actual	926
1987 Actual	1,053
1988 Actual	970
1989 Estimate	682
1990 President's Budget	792

These figures are extraordinary, especially from fiscal year 1987 through fiscal year 1990 (as proposed in the President's Budget).

COMMENDATIONS FOR CLINICAL RESEARCH

Mr. Chairman, you will recall that in its report on the fiscal year 1989 budget for the Department of Health and Human Services, the Senate Committee on Appropriations stated,

> "Clinical research which permits the evaluation of new therapies is a vital element of the Cancer Research Program. However, several difficulties are emerging in the pattern of clinical research which may hamper these valuable studies. For example, there is increasing difficulty in recruiting patients for these trials; additionally, because research patients frequently are more seriously ill than others who might be hospitalized for the same illness, appropriate and needed care for them tends to be more expensive. Currently this additional cost is not reimbursed by research grants, and frequently is also not

> reimbursed by third-party insurance carriers. The Committee therefore requests NCI to evaluate the seriousness of these difficulties and to report to the Committee, prior to next year's hearings, as to what remedies might be available and the costs involved." (Senate Report No. 100-399, page 93)

We understand the NIH's response has been sent to all members of the committee and to staff.

The American Society of Clinical Oncology strongly supports the recommendations made in that NIH report. There were two particularly important issues, patient accrual to clinical trials and the impact of third-party reimbursement policies on clinical trials.

The two issues are clearly interrelated.

Impact of Third-Party Reimbursement Policies on Clinical Trials: We support strongly the NIH's recommendations regarding this matter, which begin on page 7 of the report they have made to the Congress.

As is indicated in the report,

> "Most third-party insurance contracts explicitly exclude payment for patient-care costs associated with investigational drug research. The research exclusion has been part of most insurance contracts for many years but has not been rigorously enforced, probably because of substantial difficulties in monitoring the delivery of medical care. Recently, however, with the increased emphasis on cost containment, insurance companies have had an increasing tendency to deny claims where an investigational agent is clearly part of the therapy. The claims that are denied are not simply the additional costs of care over and above that of standard therapy, but may include the entire cost of the hospitalization, irrespective of what the cost would be without the investigational treatment."

There are two other very important statements made in the NIH report to the Congress and are contained on page 9 of the report:

> "NCI's point of view on this problem can be simply stated. We believe that, in the treatment of cancer, patients on clinical trials receive therapy that is quite likely to be at least equivalent to or possibly better than standard treatment. Indeed the NCI believes and is working hard to promote the concept that clinical trials do in fact represent standard treatment for cancer patients where no curative therapy exists. The reason is that most trials in advanced disease compare a new therapy believed superior to standard treatment, to the accepted standard.
>
> "The treatment offered them on ethical, scientifically valid clinical trials represents, therefore, the best approach medically that can be offered. For these reasons, we consider it appropriate for third-party carriers to reimburse patients for the medical care costs of participating in scientifically valid clinical trials. Note that this approach does not depend on the societal value of clinical research, which is self-evident, but rather on the conviction that, at any stage in the course of a particular patient's cancer, participating in clinical trials is the best approach medically that can be offered to that patient."

Additionally, as reported by the NIH, a number of organizations have gathered for a series of meetings on this issue. They include the American Society of Clinical Oncology, National Coalition for Cancer Research, American Medical Association, Pharmaceutical Manufacturers Association, Association of Community Cancer Centers, Institute of Medicine, Food and Drug Administration, and various volunteer national organizations such as the Candlelighters. We expect a consensus report from that group shortly.

Patients who have insurance which would pay for standard therapy are unlikely to volunteer to participate in clinical trials if they then are required to pay for the patient care component of their care. (The research costs are paid by the study sponsor, e.g., the NCI.) However, increasingly when the cancer cannot be cured with best standard therapy, and experimental treatment provides the only hope, patients have paid for such therapy themselves. Since many Americans do not have this option, the issue then becomes one of access to medical care.

Major Problem: A major problem, Mr. Chairman, which would be of concern to you, is that the Health Care Financing Administration (HCFA) currently does not reimburse for these clinical research costs. I quote from page 10 of the NIH report:

> "NCI has also met on two occasions with staff of the Health Care Financing Administration (HCFA) concerning its policies for Medicare. Currently Medicare policy is to exclude investigational therapy from coverage, since HCFA believes that treatment with agents not yet approved by the Food and Drug Administration does not satisfy the 'reasonable and necessary' criterion included in the legislative language relating to Medicare. Despite this exclusion, Medicare does pay for certain limited categories of care relating to investigational therapies.

Comment: Mr. Chairman, this is a vitally important matter to be resolved, because it already has had a profound negative affect on clinical research.

Recommendation: We are requesting that this committee develop bill report language calling upon HCFA, which this committee funds, to work closely with the NIH and other interested parties in moving toward resolution of this problem. We would be happy to review or recommend such language.

We are also working with HCFA itself, and with the Senate Finance Committee and House Ways and Means Committee on this issue as well.

We thank you for your consideration of this matter.

STATEMENT OF WILLIAM DEWEY, PRESIDENT, AMERICAN SOCIETY FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

Mr. Chairman and Members of the Subcommittee, thank you for allowing us to testify on the fiscal year 1990 budget for the National Institutes of Health. This statement is submitted on behalf of the American Society for Pharmacology and Experimental Therapeutics (ASPET). The Society is composed of over 4,000 pharmacologists who are basic and clinical researchers dedicated to improving the health and well being of humanity.

Pharmacology is the medical science which involves all actions of drugs on living systems, including the discovery and development of new drugs. The science supports and complements research in almost every biomedical research field. Pharmacologists are also charged with the critical responsibility of educating physicians in the principles of drug use. The quest for new drugs and other experimental therapies has taken on special significance as the biomedical community searches for answers to AIDS, cancer, cardiovascular disease and other ailments. In addition, pharmacology offers hope of significant advances in the treatment of addictive disorders, and other effects of drug abuse.

ASPET is a founding member of the Federation of American Societies for Experimental Biology (FASEB). We have reviewed the testimony presented on behalf of our Federation by Dr. Howard K. Schachman on April 27, 1989 and wish to endorse it strongly. We hope that you will look favorably on the funding recommendations made by FASEB and the Ad Hoc Group for Medical Research Funding.

Specifically, we feel it is imperative that Congress reverse the downward trend in the number of funded research project grants. Without an adequate number of research grants, the battle against diseases such as AIDS, heart disease, drug addiction and mental illness will be slowed if not stalled. We cannot allow this to happen. We all recognize the financial constraints under which the federal government is operating. However, we believe the government has a responsibility to fund research that is a matter of life-or-death to millions of its citizens.

The reduction in the number of funded research project grants is discouraging to both senior and younger scientists alike. It is driving scientists from the biomedical fields at a time of maximum opportunity for breakthroughs in scientific investigatory research. Worse, many of America's brightest students will be unlikely to pursuing biomedical research careers if the downward trend continues. They question whether grants will be available for them when they are ready to establish themselves. Frankly, financial rewards are greater and more stable in many other professions.

Another major disincentive to pursuing a biomedical research career is the current state of the National Research Service Awards program. You have received detailed testimony from others as to how the training grant crisis developed. We urge Congress to provide strong support to this valuable program. The Ad Hoc Group for Medical Research Funding has recommended funding 11,800 training grant positions in fiscal year 1990. We consider this the minimum number of grants that should be supported.

Given the Subcommittee's attention to the National Research Service Award program this year, we also urge you to examine the number of training positions being awarded to departments of pharmacology. In recent years, the number of pharmacological science training positions has been reduced dramatically. Given the increasing demand for pharmacologists by industry and academia, this trend also must be reversed if the nation is to maintain its preeminent role in the pharmaceutical industry and other health related fields.

In 1972, the federal government supported 815 pharmacological sciences training positions. By 1979, the number had fallen to 553. By fiscal 1988, it was down to 288. This represents a reduction of 65 percent since 1972 and a reduction of 48 percent in the past ten years. Comparisons between pharmacological science training positions and the number of total training positions at NIH and NIGMS are illuminating. In 1979, pharmacological sciences received 4.9 percent of all NIH training grants; by 1988 the figure was down to 2.5 percent. Similarly, in 1979 pharmacological sciences received 12.6 percent of all NIGMS training grants; by 1988 the figure had dropped to 7.9 percent.

Attached is a graph that clearly shows the downward trend of training grants in the pharmacological sciences.

The reduction in the number of pharmacological sciences training grants is contributing to a severe shortage in the number of pharmacologists. There are already many pharmacology positions at universities that are unfilled because of the shortage. In the decade ahead the academic community will need significant numbers of pharmacologists to replace a rapidly aging faculty. The quest to develop new drugs, both through traditional and biotechnological methods, has increased the demand - by government, industry and academia - for broadly trained pharmacologists with the ability to develop and evaluate these products for safe and effective use. Industry is increasingly being forced to conduct research overseas because of the shortage of domestic pharmacologists. This well might lead in the near future to the relocation of a number of our pharmaceutical firms to other countries where graduate education is better funded. We must maintain our leadership role in this regard.

With a reduced number of pharmacologists in the pipeline, there is little hope that this country is going to be able to fill its pharmacological research needs in the decade ahead. The training of a pharmacologist usually requires more than a decade of study at the university level. Because of this lengthy training period, it will take a number of years of sustained increases in the number of pharmacology trainees before an increased number of pharmacologists will be available. Thus, it is critical that Congress express its concern now, rather than waiting for the situation to grow even worse.

We strongly urge the committee to provide for adequate resources for the National Research Service Award program. We also urge the subcommittee to include language in the report accompanying the bill appropriating funds for fiscal year 1990 for the National Institutes of Health expressing Congress's concern about the reduction of training grants in departments of pharmacology and urging that the number of grants in this critical area be significantly increased to the more realistic levels attained in the 1970's.

STATEMENT OF WILL WACHTEL, NATIONAL PSORIASIS FOUNDATION

My name is Will Wachtel. I am 36 years old and I have had psoriasis since I was 17. I am here today as both a patient and a member of the Board of Trustees of the National Psoriasis Foundation (NPF) to request funding for the National Institute of Arthritis, Musculoskeletal and Skin Diseases at a level of $192 million. We believe that this amount is essential to maintain the viability of this Institute which has had the lowest paylines and award rates of any of the National Institutes of Health. While this amount is considerably higher than the proposed funding level, it is estimated that it will require $192 million to bring NIAMS up to the overall NIH paylines and award rates. We cannot allow this Institute to fall further behind if we expect it to produce significant scientific discoveries.

Expressing it in simple terms, psoriasis is a disease where the skin cells overproduce. The skin cells multiply so fast that they cannot be shed at the same pace, resulting in elevated lesions which appear reddish and are often covered with scales.

It is estimated that 3 to 8 million Americans are afflicted with psoriasis, meaning that one person in every 30 to 80 suffers from the consequences of this disorder. The extent of psoriasis in individuals can range from being minimal to so severe as to be functionally disabling and even life-threatening. And since both the severity and duration of bodily coverage can vary widely, it is safe to say that the only thing predictable about psoriasis is that it is unpredictable.

One thing that I can tell you is that psoriasis causes devastating psychological effects. In fact, in the majority of cases, the emotional impact is more of an impediment than the physical impact. Because psoriasis is visible and our skin is the means by which we initially define ourselves to others, people with this affliction feel anxious about being accepted in a society that places a high value on unflawed physical appearance. This further hinders one's self-acceptance and makes coping with this disease more difficult.

For myself, it is only in the last several years that I have learned to overlook people's stares and to focus on a positive self-image and to overcome self-imposed limitations. Yet it still bothers me when I overhear a curious child ask a parent, "What are those spots on that man?" And, as a single person, it is a challenge to meet single women, especially in light of the fears about AIDS present today.

These concerns and feels are compounded by the fact that the public doesn't know that psoriasis is neither contagious nor curable; this leads some psoriatics to isolate themselves and to even contemplate suicide. For example, I would like to quote excerpts from a letter the NPF recently received from a 21 year old man; we could not respond directly to him as he signed it only as "Confused of Brooklyn." He states "I have hidden this disease from most of the people I know except my immediate family. My father has spent thousands of dollars on me between hospitals, medicines, doctors, and UVB treatment but nothing worked. I get better two months a year but it all comes back. I haven't gone swimming or to the beach in 8 years . . . My friends know I have some kind of problem but are not sure what it is. I try to keep it a secret because of all the AIDS and herpes going around."

He continues, "I had and still have trouble finding girls in my life. I keep to myself and try to figure out problems on my own. I know I have a disease but do not know why. I'm giving up on myself slowly. I am at the point in my life where I can't stand it any more. I thought of suicide but can't bring myself to it. My psoriasis holds me back from doing a lot that I would like to do. I think I'm going nuts. I don't do drugs or smoke or drink and am a pretty good person . . . My folks give me everything I need and I am not deprived of anything except on thing -- my health. I pray to God every day for it to return before I totally flip out or do something stupid. I am confused and do not know what to do."

Unfortunately, the NPF receives quite a few letters from people feeling desperate. The tragic thing about this one is that this man is in the prime of his life and he has thought about ending it. We have to be able to give hope to this man and others like him if we expect them to become productive members of society.

In terms of hope and progress, scientists have recently been looking for genetic factors in psoriasis and ultimately hope to find the specific genes involved with psoriasis. Furthermore, there have been clues that psoriasis is related to immune system function and scientists are now realizing that the skin is an active organ and not just a covering. Research into these areas could lead to vital information in dealing with AIDS and other diseases of the immune system.

Therefore, it is crucial that the paylines and award rates of NIAMS be raised to be on a par with the overall NIH levels. In 1988, NIAMS had a payline of 149 while NIH was 171; for that same year, award rates were 28% for NIAMS versus 35% for NIH. The estimates under the President's 1990 budget are a NIAMS payline of 140 and an award rate of 17% while NIH would have a payline of 150 and a 26% award rate. I strongly urge you to break this pattern of NIAMS having consistently lower paylines and award rates than the rest of the Institutes encompassed in NIH. As I stated earlier, it is felt that 192 million dollars is needed to establish parity with the other Institutes.

I know that it is easy for me to request this level of funding and that you have the tough job of finding those funds. However, I believe that we must view increased funding as an investment in the future in several ways. One, so that we can send the message to our young people that a career in science and biomedical research is both possible and important. Also, if we want the United States to continue to be the world leader in science and technology, we must be willing to spend the money required to maintain our edge. Most importantly, we want to find a cure or at least the most widely effective treatment for people with psoriasis so that we can make them less dependent on our health care system. The economic payback will be realized by the increased number of people who are able to contribute to society.

In conclusion, please consider the paylines and award rate disparity of NIAMS in appropriating the funds so that the goal of $192 million for this Institute is reached.

I thank you for the time and consideration you have given me today and especially for your past support of NIAMS and NIH, which has produced results that have improved the quality of life for people with psoriasis. The form of treatment known as PUVA (the drug Psoralen and Ultra Violet type A light) is just one example of those results. I speak for the members of the National Psoriasis Foundation in extending my gratitude for the compassion you have shown today and in the past.

STATEMENT OF LESLIE FAIN, COMMITTEE FOR HUMANE LEGISLATION AND THE AMERICAN HUMANE ASSOCIATION

The Committee for Humane Legislation and the American Humane Association request appropriations in the amount of at least $30 million for FY 1990 for the Biological Models and Materials Section of NIH.

The Biological Models and Materials Section (BMMR) was established by NIH to fulfill, in part, the mandate of Congress as expressed in the Health Research Extension Act of 1985 (P.L. 99-158). This mandate directed NIH to establish a plan which includes the development of methods of biomedical research and experimentation which do not require the use of animals, to validate the reliability of such methods and to train scientists and researchers in the use of such methods.

Unfortunately, the BMMR has been inadequately funded. The budget for the BMMR has been $2.584 million and $3.75 million respectively for the last two years. This is less than one half of one percent of NIH's total budget of $6.7 billion. Of NIH's total budget approximately 44% or $2.95 billion is dedicated to research involving live animals.

With this tiny amount the BMMR funds centers, awards grants and contracts for services related to the development of non-animal alternatives for biomedical research. BMMR also supports the National Disease Research Interchange which provides retrieval and distribution of normal and diseased human tissue and organs for biomedical researchers interested in studying human systems directly.

Those of us in the animal protection community strongly support the development and use of alternatives to live animals in biomedical research. The Congress mandated the development of alternatives as a specific goal and we urge the committee to increase funding to the BMMR. In addition, we also request the Committee to ask the BMMR to make a detailed report on the use of the funds.

We request this because there is apparently a lack of commitment on the part of NIH to P.L. 99-158. This is evidenced by the method in which BMMR solicits grant applications for development of non-animal alternatives. The current method is the issuing of a "Program Announcement" rather than a "Request for Application." The "Request for Application" is taken much more seriously by the research community and indicates a serious commitment on the part of the agency. The "Request for Application" specifies a dollar amount available and requires BMMR to report on how the grants are awarded. Under the current system of using the "Program Announcement" no accounting or report is required by BMMR on where the grant money goes.

We believe this program will be much more effective if this subcommittee implements the following steps:

(1) increase funding for BMMR to FY 90 to at least $30 million;

(2) require the BMMR to issue a report listing which projects

were funded, including the identification of each grant awarded; and require the use of the "Request for Application" in the future so that the accountability will be inherent in the grant process.

STATEMENT OF PETER W. CARMEL, M.D., CHAIRMAN, NATIONAL COALITION FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS

Mr. Chairman and members of the Committee, my name is Peter Carmel. I am Chairman of the National Coalition for Research in Neurological and Communicative Disorders, better known as NCR. I am also a practicing neurosurgeon at the Neurological Institute of Columbia University in New York City.

I am honored to have the opportunity to appear before you today on behalf of the NCR, a coalition comprised of more than sixty of the largest Voluntary Health Agencies and professional medical and research societies in the nation. I am fully aware of the interest that you, Mr. Chairman, and the members of this most important appropriations subcommittee have shown for increasing Neuroscience research by appropriating funds for the NINDS and the NIH.

Last year, the NINDS Advisory Council reported, at the request of the Congress, that Neuroscience research was "at an explosive period of its existence, and that in order to capture the extraordinary opportunities at hand, a quantum increase in funding for the NINDS was required". We are also mindful and exceedingly grateful for the support that this committee has given to House Resolution H.J. Res.174. "The Decade of the Brain Resolution," introduced and sponsored by a most distinguished member of this committee, Mr. Conte. This resolution needs to have the strong support of Congress if it is to have meaning. Specifically, it needs action by the Appropriations Committees in both Houses, to increase funding for Neuroscience research in a substantial way. It needs the support of the authorizing committees as well, so that long-term advances can be realized based upon the research at hand today.

As a neurosurgeon, it is particularly touching to have Nicholas A.

Buoniconti here before the committee today. His presence highlights an enormous health problem in this country, the problem of trauma to the brain and spinal cord. Congress recognized this problem by creating a special intra-agency task force on head injury, and requesting they report their findings back to Congress. That report has now been released to the Congress, and points out the tremendous cost to this country, both in terms of cost of illness, and in terms of lost income. The NIH Advisory Committee estimates that almost one million cases of head and spinal cord trauma occur every year. Their estimate of the cost of the hospital and rehabilitation care alone is nearly five billion dollars. Currently we are appropriating less than one/one thousandth of this cost for head and spinal cord injury research.

Two poignant examples from my own practice may demonstrate for you the importance of your support for this sort of research. The first of these patients is Mrs. S.. who I saw first when she was 55 years old. She had been rendered paraplegic by a fracture of her lower neck region in an automobile accident. After a period of rehabilitation she was able to resume a useful occupation, despite her wheelchair-bound existence. However, when I saw her, some three years later, she was beginning to lose the power in her hands, and the muscles between her fingers were starting to atrophy. Getting to the base of the problem would have been an enormously difficult process only ten years ago, and the diagnostic tests available would have likely not revealed the true cause of her condition. However, with the utilization of a magnetic resonance image (MRI) scanner, we were able to quickly pinpoint the source of her problem. She had a post-traumatic cavity filled with fluid inside the spinal cord itself. Appropriate surgical drainage of this cavity permitted the function of her hands to return over the next few months. She is now at work again, driving her wheelchair, car and using her word processor.

Another graphic case is that of Helen T. I first met Helen when she was nineteen years old. She had been returning from Christmas vacation with some college classmates when their car skidded off an icy road. She wound up in a local upstate New York Hospital in a comatose state. Over the next several days she slowly became somewhat more rousable and even followed some simple commands. She was transferred to our institution for management of her head injury and for rehabilitation. Although Helen made some early gains in our hospital, she soon obviously progressed downhill, and lapsed into an even deeper coma. Again MRI quickly revealed that she had a traumatic-induced hydrocephalus. Surgical treatment was able to alleviate her increased intracranial pressure and she has now made a very nearly full recovery.

The basic research into the medical applications for the MRI scanner was funded in major part by this committee. Your actions in increasing this area of research have permitted the repetition of histories like these two patients many thousands of times over across the country. The outlining of the late effects of head and spinal cord trauma would not have been possible without the MRI. When I was a resident we were told that these long-term effects were degenerative changes in the head and spinal cord and not treatable. Thousands of patients each year will be restored to function and to comprehension because we understand these long-term complications, thanks to MRI scanning.

In many laboratories, research techniques for restoration of lost function in the brain and spinal cord are underway. Exciting efforts at regeneration and reinnervation in both brain and spinal cord are reported. By transplanting cells that normally produce hormones or the cells that create the insulating material of the brain, it is possible to restore damaged areas of brain to their prior function. A multitude of avenues of research give hope that many, perhaps even the majority, of patients who undergo severe head and spinal cord injury will be restored to function and resume a normal place in our society.

I would like to conclude my testimony at this time and thank the Chairman and this committee for the support and attention that they have given to NCR over the years. Most especially we would like to thank you for the financial support that you have given to Neuroscience research.

STATEMENT OF THE PAGET'S DISEASE FOUNDATION

The following testimony is submitted on behalf of the budget request for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) and to acquaint the subcommittee with the need for research on Paget's disease of bone, a disorder which affects an estimated 2,000,000 or more individuals over 50 years of age.

The President's FY 1990 budget request for NIAMS is $168.588 million, which would only mean a $7 million increase above the FY 1989 funding level. Because the NIAMS has the lowest award rate of any NIH Institute, this budget request is particularly critical this year. In addition the number of new and competing grants will significantly drop from 185 to 129. Without adequate funding the causes and needed new therapies for diseases such as Paget's disease will not be forthcoming. Also, without the promise of NIH support, young investigators will be reluctant to undertake research for those diseases which desperately need their skills. Therefore we ask that Health (Function 550) funds be increased. We request consideration of an allocation of $192 million for NIAMS for 1990.

Paget's disease of bone, the nation's number two bone disease after osteoporosis, is a chronic skeletal disorder which often results in enlarged and deformed bones in one or more regions of the skeleton. Hundreds of thousands of sufferers of experience extremely painful and debilitating symptoms. The disease may first be noticed in the bones of the leg, the pelvis, the spine, or the skull. When the skull is affected, the head slowly enlarges and the patient may have difficulty finding a hat which fits. Affected leg bones tend to buckle under the weight of the body and become bowed. When the spinal column is involved it is not unusual for a person to shrink in height as the disease progresses. A painful disability of the hip joint can ensue when the pelvis is involved. Although bone pain and deformity are the most typical symtpoms, other complications such as deafness, susceptibility to fractures, cardiovascular problems and neurological disability may occur.

The Paget's Disease Foundation is the only voluntary health agency in the country which assists Paget's disease sufferers and the medical professionals who treat them.

The Paget's Disease Foundation has a commitment to make known to the public that treatment is available; to assist individuals affected by Paget's disease; and to provide up-to-date information to the medical community.

Many of the world's leading specialists serve on the Foudation's Advisory Medical Panel. With their help and guidance, the Foundation:

* Encourages patients to seek proper care.
* Provides information to physicians and other health professionals.
* Advocates the need for research into the cause, prevention and treatment of Paget's disease.

The Paget's Disease Foundation works closely with the NIAMS to encourage research on Paget's disease. In December of 1988 NIAMS issued the First Program Announcement seeking grant proposals for Paget's disease research. The Foundation is very grateful for this important announcement and requests the support of Congress to assure funding for research projects which might result from it.

Adequate commitment to medical research now will reduce health care costs "down the road". The Health (Function 550) Budget must be increased in order to accommodate modest growth in biomedical research supported by the National Institutes of Health and especially for the extremely important research under the purview of the NIAMS.

The Paget's Disease Foundation looks forward to a continued partnership with the Congress and the NIAMS to improve the life of Paget's disease sufferers.

STATEMENT OF PRISCILLA CICCARIELLO, CHAIR, NATIONAL MARFAN FOUNDATION

Senator Harkin and members of the United States Senate SubCommittee on Labor, Health, and Human Services, Education, and Related Agencies of the Appropriations Committee, I thank you for the opportunity to present testimony on behalf of the 30,000 Americans afflicted with Marfan syndrome.

I am Priscilla Ciccariello, Chair of the National Marfan Foundation, the Coalition for Heritable Disorders of Connective Tissue, and a Board member of the National Organization for Rare Disorders. The primary focus of this testimony is on behalf of the National Marfan Foundation (NMF), a small not-for-profit national health agency working to help patients with Marfan syndrome, their families, and their future generations.

Marfan syndrome is a potentially fatal genetic disorder of the connective tissue characterized by tall stature, long limbs and fingers (some medical historians have suggested that Abraham Lincoln may have suffered from Marfan), scoliosis, cardiac complications (the most common is aortic aneurysm), and subluxation of the lenses of the eyes. An estimated 30,000 people in the United States have this condition, but for a number of reasons many do not know they have it.

This leads me to three specific concerns of the Foundation:

(1) The lack of knowledge about Marfan syndrome in the public and in the medical profession which hinders diagnosis and treatment.

(2) The lack of clinical and basic research on Marfan syndrome funded either intra or extramurally by the National Institutes of Health.

(3) The need for more clinical research centers throughout the country for diagnosis, treatment and research on heritable disorders of the connective tissue.

First, the lack of knowledge about Marfan syndrome. I have spoken to physicians, many of whom have said they heard only two to three minutes on Marfan in medical school, or only heard about it named in one lecture on connective tissue disorders. With this little focus, the misdiagnoses, or missed diagnosis are much more understandable. Many people with Marfan syndrome go years without diagnosis. All too often, this leads to an unnecessary death.

One such person was Flo Hyman, the Olympic volleyball player who died in January of 1986 of a ruptured aortic aneurysm associated with Marfan syndrome. Another was my son who was diagnosed at autopsy (age 22). My husband also died (age 59) from complications of Marfan syndrome. Two of my other sons and several of my grandchildren are also affected. Those of us in the NMF hear many stories of tragedy, and sadly, these same kind of stories are repeated by millions of Americans affected by more than 5,000 known rare disorders. The report of the National Commission on Orphan Diseases, recently submitted to Congress, found that more than 50% of patients with rare diseases went more than five years (some more than 10 years) without a diagnosis of their disorder.

Little is known about Marfan syndrome and other heritable disorders of connective tissue because there is virtually no clinical or basic research underway. Current funding at NIH for studies which address Marfan syndrome is well below $800,000. This is distressing to the NMF because only an estimated $400,000 of this figure is devoted to primary research on the Marfan syndrome. This primary category includes 5 grants--8 grants primarily address other disorders. There are no specific studies on the basic molecular cause of Marfan syndrome.

The Marfan syndrome is a complicated disorder affecting many systems in the body, such as cardiovascular, musculoskeletal, ophthalmologist, and endocronological. Its diagnosis is very difficult. It may well be broken down into several types since so many combinations of characteristics exist. These refinements can only grow out of greater understanding of the molecular cause of Marfan syndrome.

We see no evidence of clinical research regarding diagnosis and therapies being funded. The 1988 Current Clinical Studies and Patient Referral Procedure booklet (NIH publication No. 88-217) published by the NIH Clinical Center makes no mention of the Marfan syndrome nor does it have a more general listing for connective tissue disorders.

With this conspicuous omission at the NIH Clinical Center added to inadequate research, it is not surprising that people with Marfan syndrome die unnecessarily. At the NMF we receive calls and letters daily from bereaved families who cannot understand how their loved ones could have gone undiagnosed or treated improperly. We believe that the time has come for the National Institutes of Health to do something to fill the unacceptable gap in diagnosis, treatment and research. Thirty thousand Americans with Marfan syndrome and an additional half million with other heritable disorders of connective tissue will have no realistic hope for a better future unless the NIH in general, and NIAMs, in particular receive an adequate appropriation. With an adequate budget for NIH programs, research could be initiated which would eventually save lives and suffering for many thousands of families. Where can we turn, if not the NIH? Without a center at NIH or qualified medical institutions in other parts of the country funded extramurally by NIH, people with Marfan syndrome have little hope for proper diagnosis and care.

It is important to note that the federal government, in 1987 spent only $1.3 billion for research on all rare diseases. Of that amount, over half was spent on rare forms of cancer. This left only $640 million for the remaining 4,800 orphan diseases such as Marfan syndrome. The report also showed that biomedical researchers working on both rare and common diseases agreed that it is harder to get funding for rare disease research than for research on a prevalent disease. Researchers feel that the lack of funding is the single greatest barrier to discovery of treatments for rare disorders. The pain, suffering, and loss incurred by families affected by Marfan syndrome and other rare diseases is no lees than those affected by cancer. Why does this go unacknowledged by Congress?

Without the basic and clinical research, Americans stricken with Marfan syndrome and other rare genetic disorders have little hope for survival. I refer not only to basic survival, but to a quality of life that enables families to survive together. The toll taken by theses illnesses is enormous, both financially and emotionally. Families can be devastated since multiple family members are often affected. In many cases the wage earner dies, leaving the partner with several children in need of ongoing medical care and treatment. Drug therapies, the only treatment now known, can cost several thousand dollars per year, life long. Additionally, the open heart surgery, needed in many cases, costs thousands of dollars. All too often these families are refused medical insurance and become financially as well as emotionally devastated.

As the spokesperson for people with Marfan syndrome and other heritable disorders of connective tissue, I urge this committee to adopt the funding recommendation of $191.9 million for the National Institute of Arthritis, Musculoskeletal, and Skin (NIAMS) as supported by the Coalition for Health Funding. NIAMS is the institute primarily responsible for research on these disorders. The level of $191.9 million, if adopted by the Congress, will enable NIAMS to further its efforts in the area of basic and clinical research and will also enable the Institute to maintain its level of training grants.

As you know, NIAMS was started four years ago under austere federal budget conditions. Since its inception NIMS has been able to support a very low percentage of its approved research grant submissions compared to the other National Institutes of Health. NIAMS receives many high quality proposals, which (as is done throughout all the NIH) are rated as priority scores--100 being the best score, to 200, among approved scores. Other small institutes similar to NIAMS regularly fund up to a 180 priority score whereas NIAMS must make its cut-off at 150. The award score will go to 140 in fiscal year 1990 and the award rate will be even lower unless this committee provides the $191.9 million appropriation.

Last year a similar crisis faced NIAMS and Congress added a specific $3.1 million add-on to allow NIAMS to remain at a relatively stable funding level. We are grateful that you took that step last year and hope that you will provide adequate funding this year to ensure that NIAMS can continue its vital research and other programs. We trust that this will provide for new research on those disorders which have up to now received little attention.

STATEMENT OF THE MEDICAL LIBRARY ASSOCIATION

The Medical Library Association welcomes the opportunity to speak publicly in support of adequate FY 1990/91 appropriations for the National Library of Medicine (NLM). The Medical Library Association (MLA) is a professional organization of about 5,000 individuals and institutions who organize and manage biomedical information to support the needs of physicians, scientists, patients and students in health care settings and education centers across the U.S. Because innovative research and quality patient care require speedy, efficient access to a full range of information resources, MLA members are leaders in the application of information technologies to information problems. This leadership is nowhere more visible that in the programs and services of the National Library of Medicine. MLA supports a budget of $104,229,000 for the National Library of Medicine in FY 1990/91, an increase of $26 million over the President's request of $78,229,000. Specifics of our recommendations are highlighted below.

••• *Current Services ($1.4 million increase)*

A model of excellence in its daily operations, NLM sets the standard for other medical libraries to follow in bibliographic access and retrieval. By sharing its resources, providing access to its own operational databases, and managing the DOCLINE network for interlibrary sharing, NLM provides invaluable support to other health sciences libraries. Increased costs for acquiring biomedical literature, particularly journal literature have forced many small health sciences libraries to cancel expensive, albeit important subscriptions. This unfortunate circumstance increases the demand for borrowing from NLM's collections, requiring NLM to maintain the continuity of its own journal subscriptions. MLA supports an increase of $1.4 million for current services.

••• *Preservation ($.5 Million increase)*

NLM's active preservation program has inspired serious consideration of the use of alkaline papers by commercial and public printers, and legislation has been introduced in Congress to encourage other government agencies to follow NLM's lead. Although preservation microfilming has begun for NLM's own collections, support is needed for preserving important biomedical literature not owned by the NLM, to assure its availability to scholars in the future. MLA supports an increase of $500,000 above the current level of funding for preservation.

••• *Intramural Research and Development*

The innovations generated by NLM's intramural research and development programs provide the broad base upon which its excellent daily operations rest. The newly-established National Biotechnology Information Center has already begun work on a genetics workstation, serving as a gateway to disparate information sources which form the knowledge base of molecular science. The AIDS databases and Hazardous Substance Databank explore new ways of providing practitioners with non-bibliographic data. Work on the Unified Medical Language System projects has brought improvements to Grateful Med and the development of a metathesaurus which brings together the diverse vocabularies of medical care and research. Because their transfer to public use brings benefits to all, Medical Library Association supports continued funding for these important intramural initiatives.

In 1989, a special Outreach Planning Panel was formed to address NLM's long range plan in terms of new statutory authority to publicize the availability of its products and services. Chaired by Dr. Michael DeBakey and containing several MLA members, the Panel recommended an immediate $26 million increase in NLM appropriations, to support improvements in four basic areas. The Medical Library Association enthusiastically endorses the recommendations of the panel as outlined below.

••• *Regional Medical Library Program ($2 Million increase)*

For more than 20 years, the Regional Medical Library Program has served as the primary outreach vehicle of the NLM. Through a network of cooperating institutions, biomedical literature and access to NLM products and services has been made available to those who need it regardless of geographic and institutional boundaries. However, limited funding has prevented the RMLs from providing the proactive, electronically-sophisticated services they know are needed, particularly in remote areas where even the nearest public library may be a hundred miles away from the site of patient care. MLA supports the Panel recommendation of an immediate increase of $2 million for the RML program.

•• Access to National Information Sources ($9 Million increase)

The advent of inexpensive, high-quality computing and telecommunications technologies offers the promise that geography and the absence of local resources will not prevent a health care practitioner from getting the biomedical information he/she needs. The Panel's proposal to improve access rests on increased funding for three components of a national electronic biomedical network: (1) resource grants to small hospital libraries ($2 million), to help them acquire equipment needed to tap into the network; (2) expansion of the IAIMS program to additional sites ($6 million), building on the very important work currently underway at IAIMS sites around the country; and (3) participation in existing national networks such as NSFNET ($1 million) to take advantage of existing well-developed communication resources. MLA supports the Panel recommendation of an increase of $9 million for improving access to national information sources.

••Training, Fellowships and Demonstration Grants ($10 Million increase)

An outcome of the IAIMS programs and Unified Medical Language System research is recognition of the critical need for a cadre of skilled health information scientists to build and manage the next generation of medical information systems. Although NLM has supported medical informatics training at the predoctoral and postdoctoral levels, the scale and range of this program is simply not great enough to meet present and future needs. The Panel recommends expanding grant support for young investigators and increasing the number of competitive grants and training programs. In addition, a demonstration grant capability is needed, so that innovations developed through intramural research may be easily moved to the public domain. MLA supports the Panel recommendation of an immediate increase of $10 million for training, fellowships, and demonstration grants.

— *Intramural Research and Development ($5 Million increase)*

As the Panel examined existing programs and services at NLM, it became clear that improved communication mechanisms were needed to provide NLM with feedback to improve and, where necessary, expand its efforts. The Panel recommended a baseline survey of user needs and barriers to use of current systems/services, and an exploration of collaborative efforts with professional organizations and institutions which represent and educate users of biomedical information. MLA supports the Panel recommendation of an increase of $5 million to fund intramural activities related to the outreach program.

— *Staff Increases (17 FTE)*

In addition to the financial resources outlined above, the Panel recommends an increase of 17 FTE at the NLM. Currently, NLM staffing is below its 1984 level. With additional pressure to staff the National Biotechnology Information Center initiatives, NLM is essentially 53 positions short of optimum. The aggressive program of outreach recommended by the Panel cannot be implemented without adequate staffing. MLA supports the Panel recommendation of an increase of 17 FTE at NLM.

The Medical Library Association recognizes the fiscal restraints facing all federal programs, and the need for prudent use of our national resources. Nevertheless, the Association concurs with the Panel's judgment, as articulated by Dr. Michael DeBakey in his April 27th statement before the House Appropriations Committee Subcommittee on Labor, Health and Human Services, Education and Related Agencies, that "these expenditures would be many times repaid in the form of higher quality medical care and biomedical research and, ultimately, in lives saved." MLA urges the committee to appropriate a budget of $104,229 million for the National Library of Medicine, including the full $26 million increase recommended by the Outreach Planning Panel.

STATEMENT OF THE AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY

SUMMARY

The manpower crisis in pediatric nephrology is of such magnitude in the United States that specialized medical care for newborn infants, children and adolescents with kidney or kidney-related disorders will not be available for entire geographic regions or population segments--regardless of the need. There are 65 unfilled positions in pediatric nephrology with only 10 individuals completing training programs this year. Twice that number of pediatric nephrologists will be needed within three years.

Unless immediate steps are taken to fund additional programs to train the number of pediatric nephrologists required to meet this clinical demand, a large segment of the U.S. population will be underserved--even denied access to such specialized care. To address these problems, there must be increased Federal support for training pediatricians to become nephrologists, as either basic or clinical investigators in the area of pediatric nephrology.

We strongly urge the Congress to allocate new funds through the National Institutes of Health designated for support of two or three additional training programs in pediatric nephrology to fund the stipends and expenses (@ $35,000) of a total of six fellows ($250,000) entering training in the two or three programs the first year and each subsequent year for a total of six years. The annual awards would double in the second and third years after which the funding adjusted for inflation and the cost of living would become fixed. Because of existing constraints placed on the NIH budget for the next fiscal year, it is unlikely that these programs can be expected to be funded from existing or anticipated allocations.

Without these additional funds for training in the next fiscal year, the turning point will likely have been reached and the decision for phasing out the expert care for children with kidney disease in the United States will have been made.

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Of the 200,000 children who will depend upon one pediatric nephrologist, 12,000 will develop urinary tract infections each year, 5,000 will have vesicoureteric reflux leading to permanent kidney damage in 2,000 of them; 5,000 will require evaluation for protein in the urine; 2,000 will be evaluated for blood in the urine; 1,000 will develop diabetes--40% of them will ultimately become uremic adults and require dialysis and transplantation; 7,000 will develop kidney stones at sometime during their lifetime; 10,000 will have hypertension and 50,000 others will become hypertensive at an older age, and at least 20 others will require dialysis or transplantation for other causes during the first two decades of life.

The Federal Government now spends $3.0 billion annually through Medicare--ten fold more than its total expenditure on training and research to prevent or treat kidney and urologic disease--on clinical care for patients with end-stage renal disease, mostly in adults of which 80 per cent developed kidney failure because of a potentially preventable renal disease, like diabetes, which began during childhood. To date, no federally-funded research programs have been directed towards preventing these diseases; however, many programs have been funded to develop new treatment strategies for kidney diseases in adults which began in childhood--too late, perhaps, to interrupt the progression of renal injury. While these programs are important ones, there is little doubt that developing programs to identify kidney damage during childhood would be more cost effective and would serve to relieve the growing financial burden for treating the consequences in many of these diseases in adults. Such prevention programs would be conducted ideally by pediatric nephrologists, but the manpower crisis precludes their involvement in such innovative programs. So, in all likelihood, today's children with potentially preventable kidney diseases will keep tomorrow's dialysis units filled with adults with end-stage kidney disease and cost the government far more money than would have been spent on the research and training to prevent this costly complication.

Manpower in Pediatric Nephrology

A pediatric nephrologist is a physician trained first as a pediatrician who has completed two or three additional years in a pediatric nephrology training program learning to diagnose and treat only kidney diseases. Such programs now require three years of formal training in one of the 33 programs certified by the AMA Accreditation Council on Graduate Medical Education. The demand for the specialized medical care grew when technical advances for the treatment of adult patients with kidney disease were adapted gradually for smaller patients. These skills were acquired only recently for newborn infants many of whom had died in the past for lack of available treatment. Many premature infants now survive their lung disease only to succumb to kidney failure which is treatable. These infants contribute to the embarassingly high infant mortality rate in the United States which more like that of underdeveloped nations rather than Western European countries.

There are approximately 220 pediatric nephrologists in academic institutions within the United States currently providing some medical care to children with kidney disease. Effectively, there is one pediatric nephrologist for every 200,000 children. By contrast, there is one general nephrologist for every 60,000 adults. A majority of general nephrologists practice in the private sector; whereas, the fewer number of children with recognized kidney disease, the increased time taken to provide medical care for the child and his family, and the low reimbursement rate by third-party carriers and Medicaid/Medicare for the time and expertise gained from two or three years of additional training make it impossible for pediatric nephrologists to enter private practice dedicated only to nephrology. Pediatric nephrologists, by necessity, must be salaried employees of a medical school or large medical center.

In a recent survey conducted by The American Society of Pediatric Nephrology, 93% of Chairman/Program Directors of U.S. medical school-affiliated pediatric training programs confirmed the manpower shortage extant already in pediatric nephrology. This finding is in marked contrast to situations in Europe, Australia and Japan where experienced pediatric nephrologists cannot find permanent positions. When the survey was made in 1987, there were 37 full-time unfilled positions in pediatric nephrology in the United States. The manpower shortage in pediatric nephrology was expected to become even more critical over the next five years, by 1992 when there 125 additional pediatric nephrologists in the United States would be needed. In fact, the estimate had been an overly conservative one since by April 1989, there were already 66 unfilled positions.

There are 10 states, for instance, which have no resident pediatric nephrologist and must depend upon the resources of neighboring states or distant medical centers to provide specialized consultation and care for their young citizens. Moreover, 11 states have only one pediatric nephrologist, and seven states have only two pediatric nephrologists working together in the same major city. The manpower problem is changing in some regions as pediatric nephrologists retire, take other positions, or because of overwork, leave to join other pediatric nephrologists in another region or state. For instance, there are 3 pediatric nephrologists in Kentucky: two in Lexington and one in Louisville. One of those in Lexington has or is about to retire, the other is seeking a position elsewhere because the clinical demands cannot be handled by one individual. Efforts at recruiting an additional person at both institutions has been ongoing for the past two years, but with no prospects of filling either the replacement or new positions. Within a year, it is likely that Kentucky will have only one pediatric nephrologist, and, most likely, there will soon be no one in that State to care for the children with kidney disease. This problem is not unique to Kentucky. In Massachusetts, there are nine pediatric nephrologists and is a major training program in pediatric nephrology, but this program cannot train enough pediatric nephrologists to fill the existing and anticipated unmet demands in that state alone. A similar situation exists in Texas.

Training Programs in Pediatric Nephrology

There are 33 training programs in the United States certified to train pediatricians for careers in pediatric nephrology. The duration of such training is three years of which half the time must be spent in research. At present, there are 58 trainees in 21 of the 33 programs; however, only two-thirds of these trainees will be eligible to accept unfilled academic positions in the United States. The others are foreign nationals and must return to their countries of origin. During 1988, only eight individuals completed training and were recruited for the open positions. About 20 trainees will complete fellowships during 1989 and 1990. At the current rate of training there will be more than 100 positions in pediatric nephrology still unfilled by 1991.

In 1987, the most recent year in which the data has been made available, the Federal Government spent less than 3 per cent of its funds allocated for training in kidney diseases for training pediatric nephrologists. There were only two funded training programs at the time, one in Minnesota and the other in New York, with stipends to accept two trainees (total of four in the U.S.) each year for a three year training program. In the same year, there were 28 NIH-funded programs for training internists in general nephrology where no manpower shortfall exists. Others in general nephrology are funded through Medicare payments to hospitals providing care to Medicare-eligible adults--a resource not available to pediatric nephrologists in Children's Hospitals where the only Medicare patients are the children with end-stage kidney disease. Many trainees are paid from funds earned from patient care by the pediatric nephrologists who also provide the training resources and teaching. Others are paid from local hospital funds. Last year, an additional program in pediatric nephrology was approved by the NIH in Virginia. If that program is successful in attracting and training pediatric nephrologists, the first trainee will not complete the program until 1992.

The total number of training positions in pediatric nephrology now funded by the NIH is six--still less than 5 per cent of the NIH budget for training in kidney disease. The NIH has notified its training program directors that training grants will be phased out over the next 10 years. Part of this decision rests with the number of NIH trainees who enter private practice rather than embark on or maintain an academic career. Unlike the more than 80 per cent of trainees in adult nephrology who enter private practice, more than 90% of pediatric nephrology trainees enter and remain in academic positions--teaching medical student and residents while conducting research and providing round-the-clock medical care for patients.

The reasons given by pediatricians for not selecting nephrology for a subspeciality include financial debt incurred during college and medical school which averages $35,000 for individuals borrowing money to attend medical school.

Moreover, such individuals are unable or, perhaps, unwilling to postpone repayment of these loans for an additional three years of training which will not increase future earning potential. Finally, but not unimportantly, the salary of an experienced pediatric nephrologist working more than 60 hours a week often only equals or is less than that of a general pediatrician employed by a health maintenance organization providing better fringe benefits for only 40 hours a week and less responsibility. The pediatric nephrologist is not compensated appropriately for the time and expertise required to perform specialized care for neonates, infants, and children. The general nephrologist may take 15-30 minutes to perform a renal biopsy in a cooperating adult patient; however, to do the same procedure requires the technically proficient pediatric nephrologist to spend up to twice as much time to complete the biopsy safely in an uncooperative child which must be sedated or restrained. Moreover, heavy biopsy needles are not supported well by paraspinal muscle tissue and the individual performing the biopsy must risk increased radiation exposure to support the needle during fluoroscopy to prevent the kidney being lacerated by the needle tip. The smaller kidney of the infant and child is more difficult as well to biopsy safely with the use of ultrasonography. Everything that is done to or for a child must be explained first to parents, then the child, depending upon his or her ability to understand. This requires twice the time for advising and informing patients about diseases, procedures and therapy.

Compensation for this increased skill, longer duration of nephrology training, and increased time commitment is the same as, or often less than, that for nephrologists treating adult patients. The pediatric nephrologist, therefore, is under compensated for professional skills. An exclusive private practice of pediatric nephrology, unlike most subspecialities, is not feasible even in metropolitan areas. Job opportunities exist, therefore, only in academic settings usually located in urban areas. Furthermore, the choice of life styles is not conducive to a career in pediatric nephrology because clinical demands leave little time for hobbies, avocation, and family. Reasons given by pediatric nephrologists for leaving the subspeciality for other positions is summed up as poor job satisfaction or "burnout" due mainly to too few individuals sharing too much of the clinical burden for both private and public patient care.

For those few individuals making the commitment for an academic career in pediatric nephrology, the likelihood of being successful in obtaining extramural funding for research is impaired greatly by the clinical demands placed upon the individual. As a result of concerted efforts by the American Society of Pediatric Nephrology and the National Institutes of Health, funding for R01 grants submitted by pediatric nephrologists has increased from 12 in 1982 to 32 in 1986. However, this compares unfavorably with the total number of grants given to adult nephrologists which numbers 323. It should be pointed out that this proportion remains unfavorable to pediatrics even if adjusted for the difference in number between University based adult and pediatric nephrologists. As long as the measure of academic productivity and job success remains the number of papers in scientific publications and the amount of competitive funding secured for research projects, the prospects for any pediatric nephrologist with major clinical responsibilities being promoted and awarded tenure on medical school faculties remains highly unlikely and nearly impossible.

Pediatric nephrologists have traditionally been leaders in pediatric research. Initially research emphasis was focused upon renal embryogenesis, the physiology of the kidney in utero and in the transitional period into the extrauterine environment and upon composition and reparation of body fluid compartments in early life. Later advances in the immunobiology of glomerulonephritis, in the application of transplant immunology in children and in the provision of dialysis therapies to small and growth retarded children are provided by pediatric nephrologists. Currently pediatric nephrologists are determining the genetic basis of renal metabolic disorders, the molecular basis of hypertension, the pathogenesis of renal cyst formation, the basis for renal immune-mediated injury and determinants of renal growth following injury to the kidney. Resources to pursue these and other vital areas of basic research interests are extremely limited. Moreover, multi-center clinical trials and individual pediatric nephrology research studies are advancing the knowledge base for disease recognition and have the potential for intervention to prevent the consequences of disease being manifest later in life. In the future greater emphasis must be given to improving the funding for both basic and clinical research initiatives as well as research training in pediatric nephrology if continued advances are to be expected.

Recommendations

To address these problems, there must be increased Federal support for training pediatricians to become nephrologists, as either basic or clinical investigators in the area of pediatric nephrology.

We strongly urge the Congress to allocate new funds through the National Institutes of Health designated for support of two or three additional training programs in pediatric nephrology to fund the stipends and expenses (@ $35,000) of a total of six fellows ($250,000) entering training the first year and each subsequent year for a total of six years. The annual awards would double in the second and third years after which the funding adjusted for inflation and the cost of living would become fixed. These centers should be in an institution where a critical mass of pediatric nephrologists and research activity could be organized for training and equipping post-doctoral fellows with research skills to conduct their own independent research pursuits. Such would not be possible to establish at each of the 33 training programs. The responsibility for the development and oversight of such a program would fall to the NIDDK or NICHD since the latter institutes have a concern for scientific investigation in renal development and disease and the long term well being of children. Because of existing constraints placed on the NIH budget for the next fiscal year, it is unlikely that these programs can be expected to be funded from existing or anticipated allocations. Without these additional funds for training in the next fiscal year, the turning point will likely have been reached and the decision for phasing out the expert care for children with kidney disease in the United States will have been made.

STATEMENT OF MERWYN BAGAN, M.D., AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear here today to discuss the research programs of the National Institutes of Health, and in particular those of the National Institute of Neurological, Communicative Disorders, and Stroke.

I am Merwyn Bagan, M.D., a neurosurgeon in private practice in Concord and Manchester, New Hampshire. I appear here representing the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), which have over 3,000 neurosurgeon members. With me today is Roy A. E. Bakay, M.D., Associate Professor of Neurological Surgery, Emory University, Atlanta, Georgia and a principal investigator in tissue grafts. He is also a consultant to the Office of Technology Assessment.

I want to take this opportunity to thank each Member of the Committee for your past support of initiatives organized neurological surgery has considered to be important. Specifically, I want to make mention of the seed funds you made available last year to develop a uniform Head and Spinal Cord Injury Registry at the Centers for Disease Control. When fully implemented it will provide important data for the evaluation of prevention programs, improvements in hospitalizations and for the development of more efficient and effective rehabilitation programs. We are also looking forward to the final report of the Congressionally mandated "Interagency Task Force on Head Injury." This, coupled with the landmark Institute of Medicine Study "Injury in America," will give us a focus in dealing with head injury and spinal cord injury which are responsible for more deaths of citizens between the ages of 14 and 32 than all diseases combined.

Mr. Chairman, we are aware that head injury and spinal cord injury is a problem that requires attention from all sectors of our society. To that end, our associations are doing something about it in many different areas from science to prevention. One example is the AANS and the CNS National Head and Spinal Cord Injury Prevention Program. The two organizations developed this program to decrease the number of severe head and spinal cord injuries, particularly among the high risk young adult and teenage population. This program was established in 1986. To date, approximately 100 neurological surgeons are donating their time to these programs. The program is operational in 40 states and we have reached more than 400,000 students. Our preliminary data indicates that we are influencing attitudes and behavior concerning automobile and recreational safety habits, within the targeted age group. Incidently, the program has received a Presidential Citation and the film we use as part of the program, entitled "In Harm's Way," has received five major awards. I have copies of the film and will be happy to give you one.

Mr. Chairman, as a "Decade of the Brain" initiative, this year we suggest this subcommittee provide funds to the NINCDS to establish up to six multidisciplinary centers involved with basic and clinical research on central nervous system grafting.

Currently there are approximately 22 programs in this country performing adrenal medullary grafting in man, and there have been at least 100 patients grafted in the United States with adrenal tissue.

Members of the Committee, keep in mind that while the proposed centers would focus initially on Parkinson's disease the expectation is that the programs would evolve into other areas where grafting may be applicable. Since the underlying basic technique is very similar, other diseases may be investigated as the basic science studies resolve the technical problems. Although the initial target population of those with Parkinson's disease or similar movement disorders would be estimated to be approximately one million, there are other diseases such as Alzheimer's with approximately three million patients who could potentially benefit. Attempts have already been made to graft patients with diseases such as Huntington's and Progressive Supranuclear Palsy. The number of patients with these diseases is relatively small but again the same basic grafting techniques are being used and therefore other diseases may eventually fall within the realm of potential treatment with grafting. The emphasis must be on the clinical research programs to continue generating patient correlations to identify the problems which basic science will need to resolve and to acquire the information and expertise that can only be obtained through the study of humans. The ideal center would include a large clinic specializing in movement disorders. This would provide the patients for surgery and other research protocols. The combination of clinical and basic science research would have a powerful and persuasive value.

The personnel involved would have to include a neurosurgeon who is familiar with grafting techniques. He or she should also be familiar with stereotactic techniques since this is the direction in which grafting is heading. The key element of the group will be the neurologist or ideally neurologists who have expertise in movement disorders.

Other essential personnel would be a neuropsychologist, a neuroradiologist, and a nurse clinician or a physician assistant who specialize in neurologic disorders. The basic scientist would be working in conjunction with the clinicians on studies involving both patients and animals. The nature of this research could be biochemical, anatomical, electrophysiological, etc., and would involve a recognized expert in the particular area being evaluated.

One could envision these centers to be similar to the epilepsy centers which were created to advance epilepsy research on both the clinical and basic science level. These epilepsy centers provided the critical nucleus to offer comprehensive epilepsy care and to evaluate the results of surgery for patients with medically intractable epilepsy. A spin-off was the generation of a tremendous amount of research on the basic mechanisms of epilepsy.

I want to emphasize that the protocols of the proposed centers will comply with all rules applying to the use of fetal tissue.

Mr. Chairman and Members of the Committee, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons propose that you provide new funds to support six multidisciplinary centers for five years at a first year start-up cost of $450,000 per center and full operational costs of $900,000 per center in year five.

STATEMENT OF NEWTON C. MCCOLLOUGH III, M.D., AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

I am Newton C. McCollough, III, M.D., President of the American Academy of Orthopaedic Surgeons. I am also Director of Medical Affairs for the Shriners Hospitals System headquartered in Tampa, Florida.

I am pleased to appear before you today to present the Academy's position on the continued and, hopefully, expanded funding of research on the musculoskeletal system at the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS).

The musculoskeletal system encompasses the (1) bones; (2) joints; (3) muscles and the nerves that control them; (4) tendons; and (5) ligaments, all of which enable each of us to perform the tasks of every day living.

As I am sure you are aware, Mr. Chairman, diseases of the musculoskeletal system rank among the most common causes of pain, and disability. In addition to the toll they exact in human suffering, the economic impact of these disorders exceeds $65 billion annually, when measured in terms of the added costs of medical care and lost productivity.[1/]

Mr. Chairman, on an annual basis more than 40 million people suffer from bone and joint disorders, fractures, and injuries of the tendons and ligaments; approxi-

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[1/] The Frequency of Occurence, Impact, and Cost of Musculoskeletal Conditions in the United States. Troy L. Holbrook.

mately 37 million Americans suffer from arthritis, a disease that encompasses more than 100 different disorders of the joints and connective tissues, including osteoarthritis, rheumatoid arthritis, systemic lupus erythematosis, gout, and ankylosing spondylitis, or what is commonly known as spinal arthritis. Numerous others are afflicted with bone cancer, cerebral palsy and osteoporosis.

Scope of Research

The research opportunities in the Arthritis and Musculoskeletal and Skin Institute are as varied as the diseases it is attempting to learn about.

The field of orthopaedic research supported by the NIAMS includes:

- basic and clinical studies of normal bone, bone growth, and bone metabolism;
- bone and joint diseases, injury, and repair;
- therapies such as joint replacement, and bone and cartilage transplantation to treat these disorders.

Research Advances

The investment in musculoskeletal research continues to provide a substantial dividend to the American taxpayers. The following are but a few of the most recent research advances in the prevention and treatment of musculoskeletal diseases:

- Understanding of the bonding of the myo-fascial junction has led to a better understanding of the mechanism behind muscle tears and how to prevent them.
- Further understanding of the role of growth factors in bone, cartilage and fibrous connective tissue suggest exciting new possibilities for controlling repair of damaged or diseased states.
- Additional understanding of the mechanisms by which artificial joints fail at the interface with host bone resulted from demonstration of the ability of particulate methyl methacrylate (bone cement) to induce a bone resorbing cell membrane.
- Long term reports of large segment bone and cartilage allografts (transplants) in weight-bearing joints indicate that an 80% success rate can be

Research Opportunities

Bone Growth Factors

That bone remodeling and repair and induction of new bone formation are controlled by systemic hormones has been known for many years. Research has demonstrated that a large number of locally produced factors also participate in the regulation of bone turnover, and their imbalance may play an important role in osteoporosis and osteomalacia. Technological advances in maintaining bone cell cultures have enabled scientists to study the effect of pure growth factors. Several factors appear to be of particular importance in stimulating bone formation. These include insulin-like growth factor-I, transforming growth factor-beta, and human skeletal growth factor. Stimulating bone formation in osteoporotic patients by using growth factors produced by recombinant-DNA technology is an exciting prospect that needs to be pursued.

Investigators have uncovered a link between the body's immune system and the skeletal remodeling process. Scavenger cells called macrophages, which absorb and remove waste products, also release factors that promote the growth of bone-forming osteoblasts and mature cartilage cells. Macrophages and lymphocytes produce other factors that cause bone-resorbing osteoclasts to become more active. Two such factors, interleukin-1 and lymphotoxin, have been shown to mediate hypercalcemia and possibly bone destruction in some patients with multiple myeloma.

Finally, a factor called bone morphogenic protein has been described. When injected locally into soft tissue, it leads to the formation of bone. Such a factor may be important in fracture healing, and even though preparations thus far are relatively crude, it has already been used to stimulate growth of bone to repair skeletal defects. The isolation of this factor would have many practical applications in orthopaedic surgery.

Low Back Pain

Five major factors have been implicated as causes of low back pain: mechanical problems, injuries, acquired conditions, infections, and tumors. In addition, emotional problems and stress-related tensions are believed to aggravate back problems.

The etiology of low back pain and its optimal treatment are uncertain. New research directions are being developed with emphasis on a multidisciplinary approach necessitated by the complexity of anatomic support structures and neurologic pathways. An important new and innovative diagnostic tool, magnetic resonance imaging (MRI), is now being used more widely in the diagnosis of spinal conditions. Without radiation, MRI can disclose both anatomic and chemical information about tissues. The technique requires little patient preparation, is noninvasive, and patient acceptability is generally high.

A 1980 workshop "Idiopathic Low Back Pain" emphasized the magnitude of the importance of the problems of low back pain. A second workshop "New Perspectives in Low Back Pain Research" held in May 1988 emphasized new directions for research.

This workshop, cosponsored by NIAMS and the American Academy of Orthopaedic Surgeons, identified new areas of research on muscle, nervous system, intervertebral disc, and supporting structures of the spine.

Mr. Chairman, treatment of musculoskeletal diseases has dramatically changed over the past two decades, as a result of improved knowledge of the basic nature, causes and natural history of the disease processes. New technology involving diagnostic and treatment modalities has greatly improved the results in people suffering from afflictions of the musculoskeletal system.

Unfortunately, the President's budget for 1990 does not meet the needs of biomedical research. The efforts of this committee to maintain the momentum in science and its attempts to bring hope to those individuals suffering from disease are severely cut short in the 1990 budget.

In fact, Mr. Chairman, since its inception as a separate Institute, the NIAMS has only been able to support a very low percentage of its approved research grants -- a level far below the NIH-wide average. The award rate will drop even lower under the President's 1990 budget.

We greatly appreciate this committee's efforts last year to correct this situation by adding money to the NIAMS budget in order to fund high quality research. While this effort is commendable, more needs to be done in order to bring the Institute's award rate up to a level comparable to the other Institutes.

With this in mind, we respectfully urge this committee to provide $192 million for the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

On behalf of the over 12,000 members of the American Academy of Orthopaedic Surgeons, I want to thank you for your past support and for giving me this opportunity to testify before you today.

I will be happy to answer any questions.

STATEMENT OF CHARLES PUTNAM, M.D., CONJOINT COMMITTEE ON DIAGNOSTIC RADIOLOGY

My name is Charles Putman and I am Professor of Radiology and Vice-Provost for Research and Development at Duke University. I am here on behalf of the Conjoint Committee on Diagnostic Radiology, where I serve as Chairman.

In the way of background, the Conjoint Committee is composed of representatives from the American College of Radiology, the Association of University Radiologists, and the Society of Chairmen of Academic Radiology Departments. The idea of drawing these organizations together was first conceived in 1978, in part, because of the astonishing rate at which this field has been progressing.

As you well know, Mr. Chairman, the past 100 years have brought tremendous advances in medicine. Life expectancy has been increased, many communicable diseases have been eradicated, and it seems as though every day brings forth new therapeutic agents to help cure or treat the diseases of man.

I am proud to say that the field of diagnostic radiology has played a significant part in these advances.

In the nearly 100 years since the discovery of the x-ray, diagnostic radiology has become one of the most rapidly evolving specialties in medicine. I would go so far as to say that this discipline has itself experienced more dramatic changes in the past 2 decades than any other specialty. Revolutionary new imaging techniques now allow us to observe not only the details of the anatomy but of the body's function as well.

Make no mistake, I am not talking about esoteric scientific theories or some space-age gadgetry hidden in someone's laboratory.

Today, medical imaging procedures account for, or contribute directly to, the final patient diagnosis in more than 75 percent of all hospital admissions. I might add that over the past 5 years these procedures have found their way into the outpatient environment as well.

The fact is that advances in imaging techniques have enhanced the diagnosis and treatment of virtually every disease, from diagnosing congenital heart disease in infants to helping unravel the mysteries surrounding dementia.

These and a myriad of other advancements extend well beyond the bounds of a single medical discipline, or for that matter, a single research institute. Diagnostic radiology cuts across the boundaries of virtually every discipline, from pediatrics to geriatrics, from medicine to surgery, from family practice to organ transplantation. Medical imaging aids in the diagnosis and follow-up of patients with such diverse problems as brain tumors, coronary artery occlusion, head and neck injuries, and osteoporosis.

As Dr. Williams testified recently, one need not look too far into the future to see that new technologies such as magnetic resonance and PET scan may hold the promise that we will soon have reliable tests for diagnosing Alzheimer's disease.

These new technologies can be used to produce cross-sectional images, or visual slices of the brain. These images reveal precise anatomic, physiologic, and metabolic information that cannot be obtained by standard x-ray techniques. Using computer processing, the radiologist is able to reconstruct an accurate, three-dimensional image of the brain.

Mr. Chairman, few would disagree that radiology may be the key to finding answers about diseases that threaten so many lives. At no time in the past has medical imaging offered more opportunities for research that could directly enhance our ability to diagnose and treat disease.

To help capitalize on that potential, you and your colleagues last year urged that NIH take steps to coordinate on-going research in diagnostic radiology, as well as develop an NIH-wide long range research plan. NIH responded by announcing recently that a coordinating committee will be convened and that a long-range plan will be developed in the coming months.

I want to take this opportunity to tell you how grateful we are for the leadership and foresight you showed in this regard. But more challenges remain.

What is still lacking is a separate, identifiable radiological research laboratory at NIH to allow for the development of a strong intramural research and research training program. This represents a significant gap because it fails to reflect the awareness and commitment of NIH to basic and clinical research in one of the most dynamic areas of medical science.

It is significant because, in the absence of an intramural program, NIH lacks a presence in a field that has a tremendous national impact on research that impacts the broad spectrum of medical science. It also is significant because it deprives other intramural investigators who stand to benefit from a synergistic relationship with new imaging techniques.

Recommendations

The Conjoint Committee recommends that NIH establish a diagnostic radiological science research laboratory. Such a laboratory would: (a) allow NIH to carry out its own program of basic biological and applied research; (b) serve as a center where young investigators can learn the latest research techniques; (c) enhance the research capabilities of other intramural research teams; and (d) help identify promising areas of investigation and lend expert advice to the extramural programs of the various institutes.

We also note that no diagnostic radiologists are currently serving on any of NIH's 14 national advisory councils. Because diagnostic radiology so closely relates to nearly every other medical discipline, we recommend that steps be taken to appoint appropriate and qualified radiologists to serve on advisory councils.

Thank you, Mr. Chairman. I would be glad to answer any questions you may have.

STATEMENT OF C. MAX LANG, AMERICAN COLLEGE OF LABORATORY ANIMAL MEDICINE

The specialty of Laboratory Animal Medicine was developed in response to a perceived need among biomedical research institutions to train veterinarians in the proper care and treatment of animals used in research. It is noteworthy that the American College of Laboratory Animal Medicine was the second specialty of veterinary medicine. Formally recognized by the American Veterinary Medical Association in 1957, it culminated the efforts of veterinarians in the two previous decades to (1) recognize the importance of animals in solving both human and animal disease problems; (2) proficiency in the special training that is required for the care and use of research animals; and (3) the best research data are obtained from healthy animals that are properly cared for in a controlled environment.

The Subcommittee on Labor, Health and Human Services, Education, and Related Agencies - throughout these deliberations - will hear and read repeated requests for funding research activities on cancer, heart disease, diabetes, cystic fibrosis, etc. It is important to realize, almost without exception, that these research programs are dependent on animals.

The Congress in the last two decades, has responded to public concerns on how animals are housed, cared for, and used in research. However, the forerunner of these concerns began in the biomedical research community, especially the veterinary profession. Members of the biomedical research community have actively worked with the Congress to ensure that these standards are, in fact, understood and implemented. However, it is frustrating because Congress has been hesitant to provide the resources to accomplish the intent of these legislative matters.

The proper care and use of research animals - including using the minimum required and consideration of alternative methods - requires: (1) adequate facilities that will minimize the influence of environmental variables that can complicate the interpretation of research data; (2) trained individuals who can ensure proper and humane treatment of animals, help to protect their health against diseases that could interfere with the successful completion of the research, work with investigators to ensure the use of the best animal model; and (3) adequate diagnostic laboratory capabilities to complement the diagnostic/treatment skills of those who are committed to the care of those animals.

The proper care and use of research animals is focused, primarily, in one small part of the budget of the National Institutes of Health. I do not mean, by this statement, to belittle the efforts of our primary government agency oriented toward the implementation of health care - for they are among the best in the world. I only want to emphasize that one small part of our health research budget is oriented towards the animals that enable us to solve those probing questions of human and animal health.

I ask you to focus on the key issues. This implementation of the amendments to the Animal Welfare Act can only be accomplished by adequate funding for research. This includes continued support for the training of personnel to adequately care for such animals; diagnostic laboratory support for quality control and disease surveillance; increased funds for renovation of existing animal facilities; and construction authority for new animal facilities. The latter is particularly important since there have been no federal funds, specifically designated for new animal facility construction for the last 20 years.

Summary

Perhaps we, in the scientific community, have been lax in emphasizing our needs. We have supported the Congress in defining the need for quality and humane care of our research animals. However, this can be accomplished only if we have adequately trained personnel to provide such care, diagnostic laboratory support, and have adequate facilities to enhance the quality of that care.

Thank you.

STATEMENT OF MICHAEL E. DEBAKEY, M.D., CHANCELLOR AND CHAIRMAN, DEPARTMENT OF SURGERY, BAYLOR, UNIVERSITY

I present this statement in support of the National Library of Medicine as Chairman of an advisory Panel assembled to advise the Library on how to conduct an outreach program to ensure that its services are used to maximum benefit by American health professionals. An Outreach Planning Panel made up of 31 physicians, scientists, information experts, medical librarians, and members of the business community was established by the Library's Board of Regents in 1988. It met three times and its final report will be submitted to the Board in June 1989.

One impetus for the Panel's creation was this Committee's 1988 report on health and human services which stated that "The Nation's immense investment in biomedical research can be maximized only if there are efficient channels for disseminating research results, and these the library provides through its computerized MEDLARS services and the regional medical library network. The Committee believes that this program should be expanded to reach all American health professionals...."

The Panelists recognized that medical information services of the kind pioneered by the National Library of Medicine are an indispensable part of research. Scientists begin their investigation in the library by reviewing the publications of their colleagues; on completion of an experiment, the findings, published for their peers to judge, are stored in the library, available to anyone who needs them. More than this benefit to scientists, however, we agreed, the databases created and maintained by the Library are of enormous value in the daily practice of medicine. We learned of a number of cases in which information in the NLM computers saved a patient's life or provided more effective treatment by the physician. We also agreed, however, that far too few medical practitioners make optimum use of these services. We discussed these problems extensively, from the diverse backgrounds of the panelists, and we distilled from our deliberations recommendations in four categories:

> Strengthening of the Regional Medical Library Network;
>
> Improvement in access to national information sources by assistance to community-based hospitals, expansion of integrated information approaches at major academic centers, and participation in emerging national electronic communications networks;
>
> Expansion of training and demonstration grants; and
>
> Expansion of the Library's intramural R & D program, including the undertaking of studies about the users and use of NLM services.

The Panel's first set of recommendations concerns the Regional Medical Library (RML) Network. Begun in the 1960s, the Network today has 7 Regional Medical Libraries covering all geographic areas of the United States, and more than 3,000 member institutions, ranging from collections at community-based clinics to major academic health science libraries. The unparalleled collections of the National Library of Medicine, of course, support the entire Network.

The Outreach Planning Panel strongly believes that the NLM should forge a new partnership with the members of the Regional Medical Library Network. The emphasis should be on bringing the benefits of NLM's medical information services to all health professionals, especially those who do not currently enjoy direct access. The Panel suggests that the Library formally review the mission, goals, and present regional configuration of the Network to see if modifications are required in the light of the new emphasis on outreach. The Panel also recommends that the NLM work closely with regional institutions to sponsor specific outreach activities designed to reach underserved audiences. In particular, we recommend that NLM's present efficient service of lending books and providing copies of journal articles through interlibrary loan be expanded to allow health professionals unaffiliated with a library to request these materials through their computer terminals. It was our judgment that in Fiscal Year 1990, the first year of the proposed Outreach Plan, an additional $2.0 million, increasing to $6.0 million in Fiscal Year 1991, would be required for the activities involving the RML Network.

Our second set of recommendations centers on the need for the NLM to strengthen the capacity of local institutions to have access to national information sources. The Panel suggested that the Library expand its existing grant program that supports community-based hospitals in providing their health professionals with the latest in information by use of modern electronic and telecommunications technologies. The Panelists recommended that this support be increased by $2.0 million in Fiscal Year 1990.

Also under the rubric of strengthening local institutions, we were enthusiastic about the Library's initiative known as Integrated Academic Information Management Systems (IAIMS). IAIMS is an ambitious program of grant support to large academic health science institutions that seeks to create integrated systems to link and relate the many computerized sources of information -- within and without the institutions -- for patient care, research, education, and administration. The Panel was impressed with the current success and the potential of the IAIMS program and strongly recommended incremental funding at a level of $6.0 million in Fiscal Year 1990. The Panel recommended an additional $1 million in the allied field of developing "gateways" for American health professionals to have access to a variety of relevant national databases.

The third set of recommendations has to do with the critical need for a cadre of health professionals skilled in the application and use of modern information systems. The Panel found existing training grant programs successful, but on much too small a scale to have a significant impact nationally. The Panel therefore recommended expanding grant support for young investigators, increasing the number of competitive fellowship awards, and immediately increasing the number of NLM-supported training programs in medical informatics from 8 to 15. A related need is for the Library to expand its program of demonstration grants, so that improvements in biomedical information techniques resulting from NLM-supported research can be developed into operating systems and shared with other institutions. The Panel believes that implementing these recommendations will require an additional $10.0 million in Fiscal Year 1990.

The last category of recommendations concerns what NLM can accomplish internally -- to find out more about its users, promote awareness of its existing products and services, and develop new products and services. As one aspect of this, the Library must identify impediments to the use of its computerized medical databases -- be they geographic, technical, behavioral, or financial -- especially among health professionals engaged in patient care. We recommended that the Library begin a nationwide baseline survey to establish the extent to which health professionals in specified categories know about, have access to, and use medical databases. In accordance with this Committee's wishes, one group we paid special attention to is the rural health professional and others in underserved areas who have great difficulty in keeping abreast of modern medical advances.

The Panel believes that the Library, using data derived from such surveys, should then engage in vigorous outreach efforts to bring to the attention of the nation's health professionals -- in all settings -- the message that they can benefit greatly from NLM's information services. Simultaneously, NLM should collaborate with governmental, academic, and professional organizations to encourage the use of computerized databases as a requirement for credentialing or quality assurance, or both. This would also provide the NLM with an invaluable source for obtaining advice and feedback to assure the Library that its services are maximally relevant. A total of $2.0 million is recommended in Fiscal Year 1990 for surveys and user studies, outreach activities, and coalition-building.

The findings from the user surveys and collaborative undertakings will have a second important application. They will suggest directions of Research and Development (R & D) for developing future services. A foundation exists in the Library's present highly successful products and services, as, for example, the innovative microcomputer-based software package known as GRATEFUL MED, which provides an easy-to-use interface in the Library's major databases. The Library already has in place a competent R & D operation -- the Lister Hill National Center for Biomedical Communications -- to aid in these endeavors. The Panel recommends an increment of $3.0 million in Fiscal Year 1990 to pursue the improvement of existing systems and the creation of new ones.

In summary, the Panel's recommendations total $26.0 million for Fiscal Year 1990. We realize, however, that to embark on such a program will require a continuing commitment of resources. The Panel therefore drew up its outreach plan through the Fiscal Year 1994. The amounts recommended for implementation range from $26.0 million in 1990 to $53.5 million in 1994. In addition, 17 more FTEs will be required to carry out the recommendations.

The Panel, in full recognition that the Federal Government faces serious fiscal constraints, unanimously concurred in the recommendations briefly described in this statement. We did not reach our conclusions lightly, but it is our judgment that these expenditures would be many times repaid in higher quality medical care and biomedical research and, ultimately, in lives saved.

STATEMENT OF J. ALFRED RIDER, M.D., CHILDREN'S BRAIN DISEASES FOUNDATION

I am Doctor J. Alfred Rider, President of the Board of Trustees of the Children's Brain Diseases Foundation. It is a pleasure to submit our statement for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies and urge that you support requests for neurological research.

I speak today specifically with reference to research funding for Batten disease. This is a neurological disorder which has an incidence as high as 1 in 12,500 births, similar to other genetic disorders. It is probably the most common neurogenetic storage disease in children.

Although there are several sub types, the usual disease manifests itself in previously normal children at the approximate age of 5 to 10 and is characterized by a slow progression of clumsiness, stumbling and failure of vision, seizures, changes in personality and dropping of scholastic grades. The disease eventually leaves them totally disabled, unable to care for themselves and usually ends in death in the late teens or early twenties and rarely in the thirties and occasionally in the forties.

Although our foundation has been very successful in getting Batten Disease to be recognized world wide, we have only been partially successful in advancing research to determine the cause of this disease. And of course, without knowing the cause, there can be no meaningful treatment. Our lack of success is fundamentally due to the fact that our small, but dedicated and energetic, foundation cannot raise enough money to carry on the significant long term research that is necessary. We have also failed in getting the National Institutes of Health to actively and aggressively pursue a program of research in this disease.

Many of you have heard of Alzheimer Disease, Huntington Disease and Tay-Sachs Disease--to mention a few. However, Batten disease is a more common inherited disorder. Batten disease has put 30,000-50,000 American children and adults on a protracted, but inevitable path to death.

Aside from the pure humanitarian aspect, you should do all that you can to support research on this disease--just from the sheer economics. Batten disease may cost families and taxpayers as much as $60,000-$100,000 per patient in nursing and medical care alone or over one billion dollars per year. This does not include the economic loss to families involved with the care of these individuals, nor the economic loss to society from these patients not being able to work and be productive citizens.

There are an estimated 440,000 carriers of the genetic trait for Batten disease in the United States. We have no way of identifying these carriers.The cause (s) of the disease is not clear. What we urgently need for Batten disease is a good carrier test and identification of the root genetic cause. Only after they have an affected child are carriers of the Batten's genetic defect identified. This cruel and inhumane mechanism of carrier "identification" should not be allowed to continue when alternatives can be developed.

Last year NIH earmarked 3 million dollars for Huntington Disease and 108 million for Alzheimer's. Last year, NIH spent an estimated $475,471 on Batten disease. Most of this money was not given specifically for Batten disease but was included in multi-purpose grants, including $100,000 for a possibly similar sheep disease in New Zealand.

While we do not object to money spent on other diseases, we feel that Batten disease patients and families deserve at least a fair shake. The only way to guarantee that research will be done in this extremely important field is to specifically earmark 2 million dollars a year for research specifically on Batten disease for fiscal year 1989-90.

It is not sufficient for the NIH to send a notice out in the Federal Register to encourage investigators to send in traditional research grants and then have them turned down--which is what has happened all too often to the scientists we have sponsored who are working in this field. If the money is specifically earmarked for Batten disease then the NIH will spend this money on Batten disease--even if they have to contract specifically for research or conduct in-house research.

Several times when I have appeared before this committee, I have been told to give the NIH a chance to sponsor research on Batten disease, but that if it became apparent that they would not or did not sponsor meaningful research that further action would be taken by this Appropriations Committee.

I think we have delayed long enough and therefore urge you to take this very appropriate action. There are over forty seven principal investigators from major universities, medical centers and institutes throughout the world interested in various phases of research pertaining to Batten disease. (See Addendum A.) It is inconceivable that with all of these scientists doing research that none of their programs are appropriate for the NIH funding.

In spite of previous statements in former appropriation bills, to wit:

> "The Committee learned that, in spite of last year's recommendation requesting research on Batten disease, little research was funded in 1988. Therefore, it encourages the National Institute of Neurological and Communicative Disorders and Stroke to again solicit applications for grants of quality for Batten disease research."

almost negligible research has been funded by the NIH for research on Batten disease in the last five years. Therefore, we are suggesting that the following wording be adopted:

> "The Committee learned that, in spite of former recommendations requesting research on Batten disease, little research has been funded. Therefore, it recommends that $2,000,000 be specifically set aside for research on Batten disease for fiscal year 1989-90."

Thus, by a stroke of the pen, you will not only earn the enduring gratitude of the thousands of patients but their families as well. These funds should enable us to determine the cause of Batten disease. This will lead directly to prevention and treatment. The future is in your hands.

STATEMENT OF THE AMERICAN HEART ASSOCIATION

The American Heart Association (AHA) is dedicated to the reduction of premature death and disability from cardiovascular diseases and stroke. In accomplishing our mission, the AHA works in active partnership with related Federal research, education, and prevention programs. One of these programs is the National Institute of Neurological Disorders and Stroke (NINDS). The AHA is pleased to present our comments and FY 1990 funding recommendation for the NINDS. Due to our interest in the use of animals in research and our concern about the Administration's proposed elimination of the Biomedical Research Support Grant (BRSG) Program, we have also included comments and funding recommendations for the National Institutes of Health's (NIH) Division of Research Resources (DRR). The numbers and dollar figures in our recommended funding levels for both NINDS and DRR contain AIDS money.

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE (NINDS)

Stroke is the third largest source of death in the United States and is a major cause of disability. Annually, stroke strikes approximately 500,000 Americans, claiming the lives of about 150,000 of these victims. The AHA estimates that in 1989 stroke-related health care will cost $13.5 billion. But progress against stroke has been tremendous. From 1976 to 1986, the age-adjusted death rate from stroke fell by 40.2 percent. However, the number of new cases of stroke is again starting to increase.

The National Institute of Neurological Disorders and Stroke (NINDS) is the Federal focal point for all neurological research, including research on the diagnosis, treatment, rehabilitation, and prevention of stroke. The NINDS funded its first program projects and clinical stroke research centers in 1961. Since the creation of the Institute, advances in the neurosciences have occurred at a rapid pace. Over the years, the NINDS has concentrated on establishing a well-trained cadre of basic and clinical neuroscientists and on developing a new core of knowledge in the neurosciences. The Institute is now pursuing exciting new areas of research, including the prevention of neurological disease and the restoration of brain function.

The NINDS Stroke and Trauma Division administers basic, applied, and clinical research investigations, including multidisciplinary research centers, population studies, and animal studies in cerebrovascular disease. Over the past two decades, as a result of NINDS encouragement, stroke has become a major focus of study at many outstanding research institutions.

The Division's 11 cerebrovascular clinical research centers throughout this Nation are a primary force of the NINDS stroke research program. As a result of the research in these facilities, the disease process of stroke is becoming more clearly defined. Also, significant advances have been made toward identifying predisposing high-risk factors and in developing new methods for treatment and prevention of stroke. Also, population studies, over a period of years, have provided NINDS-supported investigators with a special time perspective from which to evaluate long-term stroke damage and treatment effectiveness. Moreover, animal studies continue to make significant contributions to the understanding of stroke.

Stroke prevention is the main goal of stroke research. Research promotes the objectives of stroke prevention, brain function recovery, and an improved quality of life for stroke victims. Highlights of some recent and proposed NINDS studies, subject to the availability of appropriations, include the following.

o Nuclear magnetic resonance imaging has demonstrated that there are striking differences in cerebral metabolism between mild and severe strokes.

o The clinical potential of a new drug, 1-benzylimadazole, is being evaluated for its effects on platelets, particles found in the blood that contribute to the clotting mechanism.

o A multicenter randomized clinical trial is assessing the effectiveness of the drug nicardipine, a calcium blocker, that seems to prevent disability from strokes caused by a ruptured brain aneurysm. Also, NINDS is planning a clinical trial to evaluate the efficacy of heparinoid, a derivative of a widely-used anticoagulant heaprin, in preventing new clots in victims of strokes caused by blood clots. Moreover, a pilot study is testing the efficacy and optimal dose of tissue plasminogen activator (t-PA) in reducing nerve cell death in individuals stricken by stroke caused by blood clots.

o A multicenter clinical trial is evaluating whether aspirin or a low dose of warfarin, a drug that slows blood clotting, will prevent strokes in victims with atrial fibrillation, a common type of irregular heart beat in older persons. Also, two multicenter trials are assessing the risk and benefits of a widely-used surgical procedure, carotid endarterectomy, for the prevention of stroke in symptomatic and asymptomatic patients.

o NINDS-supported research has shown that the reintroduction of oxygen and glucose when the blood supply to the brain is restored induces unique metabolic activity which may be an important part of the process that results in cell death. This discovery in biological models indicates that the recovery process of brain tissue after the lack of oxygen is beyond just a reversal of stroke-caused effects. Because brain damage can continue up to four days after the onset of stroke, this observation shows that there is time to test new treatments.

The Administration's FY 1990 budget contains $501.971 million for NINDS. Although this figure constitutes a 4.58 percent increase over the NINDS' FY 1989 appropriation, it does not allow adequate growth. The opportunity for further advances in the field of stroke diagnosis, treatment, and prevention are tremendous. However, the enactment of the Administration's budget would stifle the NINDS' ability to continue and to initiate many promising stroke research programs. The impact of the Administration's budget on the Institute, as a whole, follows.

o Only 440 competing research grants would be funded, compared to 565 in FY 1989 and 595 in FY [illegible]988, at an award rate of 30 percent of approved grants, down from 37 percent in FY 1989 and 42 percent in FY 1988.

o The number of individual and institutional training awards would be held at the FY 1989 level with less than sufficient funds to cover the projected cost of inflation for biomedical research.

o The number of research centers would remain the same as in FY 1989 with a 1.2 percent reduction in funds. This important mechanism for clinical trials has been held at close to level funding for five years.

o The number of research contracts would remain constant with a .91 percent reduction in funds.

Beginning in FY 1987, NINDS placed a stronger emphasis on support for stroke research. However, since that time, growth in this area has bean much smaller. In FY 1989, funding for stroke research increased by only 4.57 percent over the FY 1988 level. Under the Administration's FY 1990 budget, stroke research support would be increased by a mere 4 percent over the FY 1989 level. With the resurgence in the number of new cases of stroke, this decline in the support for stroke research is of grave concern to the AHA.

Now that neurosciences are producing exciting findings and are accelerating our ability to treat and even prevent life-threatening and costly diseases such as stroke, the NINDS must receive sufficient funds to maintain research momentum and to initiate programs with the potential to continue the decline in stroke incidence and its debilitating consequences. To allow the NINDS to adequately fund on-going studies and to expand into new and emerging areas of stroke-related research, the AHA recommends an FY 1990 appropriation of $568.779 million, an 18.5 percent increase above its FY 1989 appropriation.

DIVISION OF RESEARCH RESOURCES (DRR)

The Division of Research Resources (DRR) is NIH's center of interest for helping grantee facilities provide humane care and housing for laboratory animals. Because animals are a crucial component of biomedical research, the AHA is concerned about the Administration's proposed 14.12 percent decrease in FY 1990 funding for DRR.

Laboratory Animal Sciences and Primate Research Program (LASPR)

The Laboratory Animal Sciences and Primate Research Program (LASPR) is responsible for supporting research projects that enable scientists to obtain and use laboratory animals and other biological models effectively in health-related research. This assistance is accomplished through grants which provide base support for overall resources and for a wide range of multicategorical types of biomedical research conducted in DRR's seven Regional Primate Research Centers located across this Nation. Also, the LASPR Program supports investigations in research and diagnostic laboratories, education of research specialists in laboratory animal sciences, development of animals and nonanimal biomedical models, enhancement of laboratory animal health programs, and the restoration of laboratory animal facilities and other activities which maintain various NIH programs.

In addition, the LASPR Program generates and circulates material on the use of biomedical models which may improve or lead to the substitution of animals in research. Also, this Program provides advice to the NIH Directors' office in creating guidelines for the humane care and use of animals in research. Moreover, the LASPR Program serves as a liaison to animal welfare and professional scientific organizations.

The Administration's FY 1990 budget includes $71.473 million for the LASPR program. This 1.22 percent increase over the FY 1989 appropriation represents an addition in AIDS funding only. Under this proposal, each of the LASPR Program components, the Regional Primate Research Centers Program, the Laboratory Animal Sciences Program, and the Biological Models and Materials Resources Section, would receive non-AIDS decreases of 1.1 percent, 1.2 percent, and 1.0 percent, respectively. Also, the Administration's budget holds constant the FY 1989 number of research centers, animal facilities improvement awards, training grants, and research and development contracts with non-AIDS reductions in funds for each, except a 3.42 percent increase in training money.

The AHA firmly believes that the LASPR Program deserves a high priority for funding. The Administration's budget for the DRR's animal program is highly out of line with its current and anticipated needs.

LASPR's animal facilities improvement grant program provides support to research facilities in meeting requirements on humane care and use of animals under both the Animal Welfare Act and the Public Health Service Act. Because promulgation of the regulations governing the Animal Welfare Act Amendments appears imminent, the LASPR appropriation must be sufficient to cover the Program's expected broadened responsibilities. At a time when the public and scientific investigators continue to be concerned about providing research animals with the best possible care, each of the LASPR Program's grant mechanisms must receive sufficient funds. In order for the LASPR Program to meet its critical needs, the AHA recommends that DRR receive $424.950 million in FY 1990, an 18.5 percent increase over its FY 1989 appropriation.

Animal facilities and properly trained animal medicine personnel are a necessary aspect of all biomedical research activities. Moreover, proper facilities and healthy animals help to insure reliable research results. The AHA's recommended appropriation for DRR will only begin to meet the need to control animal disease and and to improve the wide-spread deterioration in a majority of the research animal facilities located at biomedical research institutions across America.

Biomedical Research Support Grant (BRSG) Program

The Biomedical Research Support Grant (BRSG) Program promotes and improves academic and scientific institutions' health-related research. The BRSG Program provides individual facilities with a pool of flexible funds for particular needs, determined by the respective institution, not normally met by other Public Health Service (PHS) project grants. Allocating these research funds on-site allows the recipient institution to balance interval needs and to make the most efficient use of emerging research concepts, techniques, and talents.

The Administration's FY 1990 budget does not contain funds for the BRSG Program. The American Heart Association (AHA) urges this Subcommittee to reject the Administration's proposal to eliminate this useful program and recommends an FY 1990 funding level of $424.950 million which would allow for its continuation.

STATEMENT OF DIANE WILLIAMS, UNITED SCLERODERMA FOUNDATION, INC.

Mr. Chairman, I am Diane Williams, a scleroderma patient and founder of the United Scleroderma Foundation, Inc. I am grateful for the opportunity to present this testimony on behalf of all scleroderma patients.

I had suffered for two years before being correctly diagnosed only to find there was no scleroderma literature for lay people. I knew of no other person with this disease and felt thoroughly alone. Even in the medical community, knowledge was lacking. Unfortunately, when the Foundation was organized, I found there were many, many patients out there! I now count thousands of them as friends.

With the goals of patient contact, public awareness, and the funding of research, the United Scleroderma Foundation pioneered in the field of support for scleroderma patients. I can attest to the comfort and relief expressed by patients when finding someone who understands their problems. It is equally as important to be able to tell them that scleroderma research is ongoing and productive. With your continued funding of research centers, we look forward to the day when the elusive cure to scleroderma is found.

Scleroderma literally means "hard skin", but its many and varied symptoms can affect the entire body. The localized form, occurring mostly in children, affects the skin and underlying tissue and bone, while the systemic form also affects internal organs. The face can be drawn tight giving a mask-like effect, and oral hygiene becomes a serious problem as the mouth will not open properly. Skin on the hands also tightens with resulting crippling, and patients are very prone to infections. Circulation is impaired and cold or stress brings on a spasm of color changes in the extremities. Ulcerations occur on the fingers and are difficult to heal, while other infections are caused by a build-up of calcium protruding through the skin. Fear of gangrene and amputation is a continual worry.

Many of these symptoms make it difficult for the person to continue in their job.

Prognosis is difficult in most cases, and the patient is confronted with fear of the unknown. A major factor in the treatment of scleroderma is emotional support.

Scleroderma is a devastating disease! Symptoms can vary in intensity in a short time, and severe internal problems involving heart, lungs, gastrointestinal tract or kidneys require extreme measures like oxygen, tube feeding or dialysis.

It is with great sadness over the loss of so many "scleroderma friends" that we appeal to you for help in conquering this disease. The United Scleroderma Foundation observed the awakening of interest in scleroderma research and has seen it increase during our short existence. We appreciate the monies received in past years through your efforts, but we strongly urge that the disparity between NIAMS and the other Institutes regarding paylines be addressed. It has become increasingly evident that the government must support medical research. Recent changes in tax laws have stifled private support in these areas so you must now increase your budget allocations. It is imperative that young investigators be encouraged, for their efforts will provide future answers for this dread disease.

Thank you for allowing me time to present these important issues.

STATEMENT OF THEODORE W. VAN ZELST, MINANN, INC.

Subject: **Expansion of Medical Research, Surveillance Network and Public Education for Chronic Fatigue Syndrome (CFS)**

Mr. Chairman and members of the Committee, my name is Theodore W. Van Zelst. I am presenting this testimony for the record as an individual and as president of Minann, Inc., a foundation which has been active in the past six years on matters related to the disease defined by the Centers for Disease Control as Chronic Fatigue Syndrome (CFS). In the past, this disease had been referred to as Chronic Epstein-Barr Virus Syndrome (CEBV).

To give this Committee a cross section of information about CFS which is affecting tens of thousands of our citizens, I asked the CFS Support Groups around the country for comments to support this testimony. In 1984, there was just one Support Group; now there are more than 505. There are regional organizations and national groups in Portland, Kansas City and Charlotte. Privately funded and government supported researchers are studying CFS.

EDUCATION AND PUBLIC INFORMATION ON CFS

Paul R. Cheney, M.D., active CFS researcher, has stated:"The Chronic Fatigue Syndrome relates to a chronic, usually relapsing, and often evolving illness usually characterized by dysfunctional fatigue, recurrent pharyngitis, adenopathy, headache, low grade fever, sub-normal temperatures, muscle and joint aches, muscle atrophy, cognitive disorders and other neuropsychiatric problems ... Because of the almost inevitable influence of co-factors both endogenous (ie genetic or developmental) and exogenous (ie environmental or co-infections) makes this one of the most challenging disorders ever studied."

One of the major concerns of the CFS patients and support groups is that of Education. A typical comment came from Minnesota: "Education and communication to physicians is very important. Scientific data is essential for medical professionals who remain skeptical about CFS" And from California: "Only one doctor out of eight doctors I've seen had even read a technical paper on the subject. There are too many patients educating their doctor via copies of technical papers, reports on various medications, etc. We need a strong education program for practicing doctors."

NIH has organized a CFS researchers' meeting in Pittsburgh, and in the Washington, DC area. Another Washington area meeting is being planned. These meetings have been well attended. The NIH should increase its support of seminars and public meetings.

The Office of Communication at the NIAID reports that CFS inquiries are second only to AIDS inquiries. The CDC advises that in 1988 it responded to over 4000 inquiries on CFS. I appeal to this Committee to designate funding for a CFS Information Program for physicians and the general public.

CENTERS FOR DISEASE CONTROL (CDC)

Summarizing accomplishments of CDC in '88, Dr. Mason, Director, said, "Despite the diagnostic problems, it is apparent that CFS exists in at least some of the persons who have been diagnosed with it. In the most clear-cut cases, these are persons who were previously physically active, often over-achievers, who describe the relatively sudden onset of an influenza-like illness that 'never goes away.' The socioeconomic effect on these persons can be dramatic. Many are so severely affected that they are forced to quit work for months to years at a time or lose their jobs because they cannot carry out their duties. They often cannot qualify for disability benefits because the illness is not recognized as a legitimate disease Many become social outcasts because they are thought to have a contagious disease."

In a report, January, 1989, Dr. Mason stated: "We (CDC) are attempting to focus attention on case definition to facilitate communication and progress in research. We also provide information to the research community, practitioners and the general public on CFS in an effort to improve research, to reduce unnecessary morbidity from misdiagnoses, to assist patients coping with their illness and to increase the general understanding about what is and is not known about this syndrome. It is anticipated that the program will expand to include identification and evaluation of possible risk factors for CFS through case control comparison, including etiologic laboratory tests on clinical specimens." This Committee should encourage the expansion of the program identified by Dr. Mason including the following:

a) "To develop methodologies for evaluating the type and onsets of neuropsychological abnormalities as well as the type of fatigue in patients with CFS and apply these methodologies to patients identified in pilot surveillance.

b) Utilizing the consensus case definition and patients with CFS identified in Atlanta, enroll patients in a case-control study of CFS; evaluate clinical manifestations, risk factors for the development of CFS and potentially useful diagnostic laboratory tests.

c) To investigate suspected clusters of CFS that may be reported to CDC in order to better delineate this illness, clinically, virologically and epidemiologically."

The CDC has expanded the surveillance studies to include northwestern Nevada where there has been a cluster of Chronic Fatigue Syndrome. CDC reports call this syndrome an "emerging disease and emerging epidemic involving immunologic abnormalities." We applaud the activities of the CDC in its surveillance studies. Concern by some researchers that the study results will not be available for several years suggests that CDC undertake more CFS research as data from surveillance studies develops.

On 3/21/89, Walter R. Dowdle, Ph.D., Acting Director of the CDC, and Frederick Murphy, D.V.M., Director, Center for Infectious Diseases reported to Congress that a virus may be involved in this disease. They cited the need for outreach activities. They mentioned the great number of blood samples available from patients in the Nevada area which may be used for further studies and suggested expanded collaboration with Nevada researchers.

We encourage this Committee to designate specific funds for CFS research and for continuance and expansion of the Surveillance Network and related studies.by the CDC.

RESEARCH ----NATIONAL INSTITUTES OF HEALTH

Anthony S. Fauci, M.D., Director, NIAID, in a communication to a Committee member stated,"...The goal of this Institute as well as of other dedicated researchers, is to find the true cause of this disorder (CFS) so that it can be successfully treated. One major NIH grant has been issued during Fiscal Year '88-'89 to a researcher to study the prevalence of Chronic Fatigue Syndrome in the community.

A problem to be addressed in research is what happens to patients who allegedly recover or who have CFS in whole or partial remission. Some patients believe that they have recovered from the most severe symptoms of CFS, but then find they have very weak immune systems and are susceptible to almost any disease, germ, virus that is prevalent in an area. Their immune systems appear to have been damaged. Research is needed to learn how to correct this damage.

Research should be funded on the virologic, immunologic and neurologic aspects of Chronic Fatigue Syndrome according to CFS medical researchers.

One CFS researcher recommended: "The NIH should provide small pilot funding for specific research into Chronic Fatigue Syndrome and the related Chronic Fatigue and Immune Dysfunction Syndrome (CFIDS). There is concern that the bulk of funds are going toward long term studies the fruits of which will be many years down the road and, given the rapid changes occurring in the field, I think will be overtaken by events. It would be more effective to see smaller amounts of money directed toward pilot projects to test very specific hypotheses so that we can quickly get a handle on what is important and not important in this syndrome. The procedures for applying for small pilot projects should be streamlined."

There are indications that not enough study has been made on a variety of drugs which may be used for treatment of CFS. Selected doctors have treated patients with specific drugs and have found some success. Some of these drugs may be effective against the virus(s) that cause chronic fatigue and the associated problems. The NIH can be effective in helping direct studies in the evaluation of drugs which can be used for CFS treatment.

Anthony S. Fauci, M.D., Director of NIAID, stated in the Hearing on 4/3/89 that the CFS medical problem is real and that there are serious symptoms with measurable findings. He stated that EBV and other 'inducers' infect a significant number of people. He discussed the grants review process, review panels and study sections. He said there is a need for better diagnostic criteria of CFS. Dr Fauci stated that there is probably a need for modification of the peer review process, particularly as it is related to this type of disease. The NIAID should be encouraged to modify the review process for CFS and related diseases.

The newly organized National Chronic Fatigue Syndrome Advisory Council, headed by Anthony L. Komaroff, M.D., has established as one of its priorities: "Data on CFS patients, i.e. clinical and laboratory should be collected in two different places, one at CDC and the other at NIH. The data should be analyzed and disseminated to various organizations or interested parties. This type of data would also be useful for epidemiological analysis and in further defining the disease syndrome." This could be accomplished through a Research Center for CFS.

In a communication, Dr. Komaroff observed: "Research findings from several groups continue to indicate subtle and diverse immunologic dysfunction in patients with CFS. Preliminary studies indicate that there can be substantial impairment of the ability to think, that seems to be caused by an organic disease. Studies indicate that several different viruses appear to be reawakened and persistently active in patients with CFS. Each of these areas of abnormality needs to be pursued, in order to further the understanding of this disorder. Also, preliminary studies suggest that the Chronic Fatigue Syndrome is often identical in its symptoms, physical examination findings and laboratory test findings to the illness called fibrositis or fibromyalgia. This observation is important, because it has been estimated that 3-6 million individuals suffer from fibromyalgia in the United States at this time."

The National Cancer Institute has some projects related to CFS, one of them regarding a link to cancer, and another on cluster (epidemic) areas. This type of work should be continued by the NCI.

SOCIAL SECURITY

Support Groups supplying information for this testimony mentioned the difficulties that patients experience in trying to receive Social Security Disability Benefits. Some comments:

Minnesota: "A problem we hear about Social Security most frequently is the slowness of the application procedure. For those who have no other means of support this usually means losing their place of residence and/or accepting the largess of family and friends."

Indiana: "Social Security has been one of the most degrading processes I have ever met with. The SSA counselors, lawyers and judges are poorly informed about CFS."

Hawaii: "Changes in the Social Security Disability Act are needed to obtain more easy distribution of aid for CFS patients. At present, legal services are needed to help patients file for assistance. Patients cannot afford attorneys and are not able to do the applications alone."

Oklahoma: "A terribly sad fact in Oklahoma is that our CFS patients tend to lose their jobs and therefore their private insurance. ...In a survey we found that our group had 16 patients trying for SS Disability benefits. Only one person had the resources for the neuropsychological testing."

These quotations show a common thread of problems with the SSA. We urge this Committee to ask the SSA for redefinition of its guidelines for Chronic Fatigue Syndrome, now that the Centers for Disease Control has issued a clinical definition of this disease.

RECOMMENDATIONS

We have made this Committee aware of the CFS problem since 1984. Great numbers of patients have been identified. There is still no accurate diagnostic method, nor is there a means of treatment. Those afflicted with CFS feel that the NIH and the CDC should be doing considerably more research on CFS to try to come up with answers that will help solve the medical questions and problems.

We urge this Committee to recommend:

1) That the Centers for Disease Control expand its research on Chronic Fatigue Syndrome which it has called an 'emerging disease'. Additional funding should be made available to carry out the programs outlined by the CDC in developing methodologies , enrolling patients in case studies, and investigating suspected clusters of CFS to better delineate this illness, clinically, virologically and epidemiologically. Funding should include 12 FTEs for CFS activities.

Earmarking $1,250,000 to the CDC for programs to train physicians and health workers about Chronic Fatigue Syndrome and for CFS information programs for the general public.

2) Funding the National Institutes of Health to continue its NIAID intramural and extramural studies to find the true cause(s) of CFS so that the disease can be successfully treated. Expanding NIH's extramural long term grants for CFS research to $8,000,000.

Funding research on the virologic, immunologic, and neurologic aspects of Chronic Fatigue Syndrome in the various Institutes including NIAID and NCI.

Provide Pilot Funding (Small Grants) $1,500,000 for specific CFS research to take advantage of new discoveries.

Make $1,500,000 available to NIH for medical profession and public education on CFS including medical symposia, public meetings and information bulletins.

Under NIAID direction, establish a Research Center for Chronic Fatigue Syndrome studies including collecting and analyzing of clinical and laboratory data on patients.

3) That the Social Security Administration study the medical and economic impact of CFS and establish a policy of awareness of this disease throughout all of its offices; and that the SSA apply the CDC's clinical definition of CFS in its guidelines for dealing with the patients afflicted with this disease.

This Committee has had an interest in Chronic Fatigue Syndrome since 1984 and has continued to provide CFS patients with hope. We thank the Committee for its attention to Chronic Fatigue Syndrome, a national health problem, and ask the Committee's continuing efforts in funding research that will lead to the understanding of this debilitating disease which afflicts so many.

STATEMENT OF E. DARRACOTT VAUGHAN, JR., THE AMERICAN UROLOGICAL ASSOCIATION

The American Urological Association, The American Association of Clinical Urologists and The Society of University Urologists make the following recommendations to the House and Senate Subcommittees on Appropriations for Labor-HHS-Education Programs.

1. We support the CDC proposal for a new initiative on incontinence as a pilot project for similar studies in the future at a cost of $217,500.00 for year 1 and $224,800.00 for year 2.

2. We strongly support that additional funds be added for kidney and urological disease research training.

3. We request an additional 4 million dollars to support the KUH to avoid further reduction in ROI support.

4. We recommend full funding for the George O'Brien Research Centers.

5. We support the recommendation of the Ad Hoc group for medical research funding for the NIH budget of 667 million for NIDDKD.

I am E. Darracott Vaughan, Jr., M.D., Chairman of the Division of Urology at The New York Hospital-Cornell Medical Center and Vice Chairman of the National Kidney and Urologic Disease Advisory Board. I am presenting this testimony on behalf of the American Urological Association whose membership of approximately 6500 represents the vast majority of American urologists. I also represent the American Association of Clinical Urologists, The Society of University Urologists and The American Board of Urology.

Mr. Chairman, the Data Committee of the National Kidney and Urologic Disease Advisory Board has, for the first time, allowed us to understand the breadth and magnitude of the problem of kidney and urologic diseases in terms of death, morbidity and suffering to the American population. As mentioned by Dr. Stuart Kleit, Chairman of NKUDAB, our data revealed that the direct medical cost for kidney and urologic diseases in 1985 were around 24 billion dollars with an indirect cost of an additional 12 million dollars, because of the lack of complete data it is appropriate to say that the true costs are in excess of those numbers. Moreover, it also is clear that many of the diseases, particularly in the urologic realm, involve our aging population and since we see an increase of older individuals in our country, we can predict that the prevalence of significant urological disease will actually increase in the future. Even now approximately 10 percent of the population suffers from kidney and urological diseases, or approximately 25 million people. There are 7 million hospitalizations and 26 million clinic visits yearly related to their disorders.

In contrast to these overwhelming numbers, the urologic community is concerned that in NIDDKD only 11 million dollars was spent addressing urologic diseases and actually only 81 million of both kidney and urologic diseases together. Moreover, despite the high prevalence of prostatic carcinoma and bladder carcinoma in

FY-88 in NCI, only 2.3 percent (34 million dollars of the budget) addressed all genitourinary malignancies. In summary then, kidney and urologic diseases received only 3 percent of the NIH budget or only 0.3 percent of what is the low estimate of the cost to the country for care of these patients.

I would like to continue by addressing some specific areas of concern.

First, in order to make major inroads against urologic disease, we need appropriately trained research manpower. Dr. Jay Y. Gillenwater, testifying before this Committee last year, emphasized the need for training in urology and we will soon have the report of the NIH study on research needs in urology which should lead to more specific recommendations. However, at the moment, research training in urology is at a minimum and we would strongly oppose NIH plans to phase out training grants in the future. In contrast, we strongly support more funds for training and as stated last year, we support additional funding for the O'Brien Centers to include a training program.

We encourage existing and newly proposed centers to support new young investigators to participate in a training program from 1 to 3 years. In addition, we propose that the Institute have an active program in identifying new centers in nephrology, urology or basic science as fertile grounds for training of new investigators. Hence, with minimum additional expense, we could utilize already established programs to train new scientists.

Secondly, the National Kidney and Urologic Disease Advisory Board Data Committee has clearly identified the broad scope of the disease urinary incontinence as it affects all age groups but particularly our elderly population. It is estimated that at least 10 million adult Americans suffer from urinary incontinence. This includes approximately 15 to 30 percent of community dwelling older people and at least one half of all nursing home residents. The monetary cost of managing urinary incontinence are conservatively estimated at 10 billion dollars annually, and the psychosocial burden of urinary incontinence is great. Fortunately, NIDDKD has just completed a concensus conference on incontinence and a summary was recently published and is available from the National Library of Medicine.

One key observation at the meeting is that there are actually a number of means which are currently available to treat these people but the information is not widely distributed to physicians or to the public. Recognizing the needs in the area of urinary incontinence, The National Kidney and Urologic Disease Advisory Board has worked in coordination with the Center for Disease Control in Atlanta, and a proposal has been generated for an initiative in incontinence. This proposal has been reviewed by a number of experts in incontinence and we feel that it is a prototype program for the involvement of the CDC in other areas involving kidney and urologic disease. The goals of the project are 1. to assess the public health impact of incontinence. 2. to identify gaps in knowledge needed to design effective interventions. 3. to identify target groups for primary, secondary, and tertiary prevention of incontinence and its sequellae. 4. to design at least one demonstration project to implementation.

We feel that this is an important new venture both because of the impact of this specific disease and also as a pilot for future programs. Therefore, we would make the recommendation that monies be appropriated to budget a CDC pilot project on incontinence with an estimated year one cost of $217,500.00 and a year two cost of $224,800.00.

Another area of major concern are diseases of the prostate. The disease benign prostatic hyperplasia has gained considerable attention recently since the major treatments for the disease have been prostatectomy operations which are one of the most frequent operations performed in this country, over 300,000 per year at a cost of over 1 billion dollars. NIDDKD has sponsored a workshop on this entity in 1985 and numerous promising areas for research and potential medical management or control of the disease, were identified. However, monies addressing this disease are meager. Of the O'Brien Centers only one is addressing BPH and research clearly needs to be expanded in this area. The other common disease of the prostate is prostatic carcinoma. At the present time, in terms of incidence, prostatic cancer is second only to lung cancer, and in terms of prevalence, that is the number of men alive with prostatic cancer, it is the most common cancer. There are approximately 90,000 new cases of prostatic cancer each year in the United States and approximately 26,000 men die of prostatic cancer every year. Another way to look at the problem which brings it more into focus, is that one out of 12 newborn white males and 1 out of 11 newborn black males will develop prostatic cancer during their lifetime. The incidence of prostatic cancer in the United States is one of the highest in the world. In contrast to what I have just said, it is appalling to realize that of the entire NCI budget, only 0.65 percent (9.5 million dollars) is spent addressing this major problem which afflicts our male population. Accordingly, we need to readdress this issue and develop strategies by which to turn more attention to this common problem.

Time is too limited to discuss the entire spectrum of kidney and urological diseases. However, one of our true success stories has been the funding of the 6th George O'Brien Centers. When those applications were submitted there were an equal number of excellent applications which could not be funded because of lack of dollars. In fact, over the ensuing years, numerous other areas of promising research have developed. Earlier in this testimony, I suggested that centers be funded at the full amount that was initially suggested and that training be included. In addition,in the future, it will be mandatory to expand centers for kidney and urologic disease, both the O'Brien Center concept and specialized centers looking at the area of urologic oncology.

However, at the moment, we realize the budgetary constraints that are upon us and we would simply suggest, as we did last year, that the current centers be granted full funding so that they can achieve their goals and incorporate training.

In specific reference to NIDDKD, the urologic community is concerned of the low percent of grants approved in the Institute and feel that many scientifically appropriate grants are not being funded. Several major efforts of the Institute are impacting on ROI funding, these include funds for the modification of diet in renal disease study (MDRD), other mandated programs such as AIDS research, and of course general budgetary constraints. In order to maintain our RO1 base and our general research base in the Institute, we would support the proposal of the Intersociety Council and the National Kidney and Urologic Disease Advisory Board for an additional 4 million dollars for the KUH division of the institute.

In addition, the urological community is concerned that the review system for grant submissions is fragmented. In fact, urology grants are reviewed by 19 study sections, many of which do not have a urologist as a member or persons expert in urologic research.

We recommend that NIDDKD establish a more effective study section for urologic proposals.

Finally, the urologic community recommends to Congress to provide funds to support kidney and urologic disease at NIDDK at 667 million as recommended by the Ad Hoc group for medical research funding (the NIADDK Coalition).

I thank you for inviting me to submit this testimony and would request that the written testimony be entered into the record for this Committee.

STATEMENT OF DOUGLAS M. BOWDEN, M.D., DIRECTOR, REGIONAL RESEARCH CENTER, UNIVERSITY OF WASHINGTON

This document is being submitted to the Senate Subcommittee on Appropriations for Labor, Health and Human Services, Education and Related Agencies by the seven NIH-sponsored Primate Research Centers affiliated with distinguished universities in California, Georgia, Louisiana, Massachusetts, Oregon, Washington, and Wisconsin. All seven Centers face conditions that seriously jeopardize their ability to carry out their missions.

Summary of Requests

- Appropriate $10 million more than has been proposed for 1990 to provide non-AIDS core budget support at a level close to that recommended by peer review.
- Establish a four-year program at a level of $8 million per year that will complete infrastructure development for AIDS research at the seven Primate Centers.

Background - The Regional Primate Research Centers were established by the United States Congress in 1960. The charge was to undertake research using nonhuman primates to solve major human health problems and to provide on a regional basis the specialized facilities, breeding colonies and technology required for such research.

Today the Centers provide research animal colonies, basic services, facilities and expertise through the seven competitive core grants awarded by the Division of Research Resources of NIH. They house projects supported by more than 300 independent research grants and contracts to individual scientists that total more than $40 million. They are regional resources for the extramural research missions of all of the categorical institutes of the NIH and ADAMHA; of the NSF, FDA, DOD and other federal research agencies; and of major private foundations and societies that support biomedical research, including the American Cancer Society, American Heart Association, Multiple Sclerosis Society, Howard Hughes Medical Institutes, MacArthur Foundation and many others.

Research Programs - Because of their unique characteristics, nonhuman primates are increasingly important for biomedical research related to pressing human health problems. Research using primates is contributing to the understanding and treatment of many important diseases, including heart disease, which will claim over 500,000 lives this year in the United States; hypertension or high blood pressure, which affects one-third of our adult population; Alzheimer's disease, which now affects 2,500,000 U.S. citizens and which will become even more devastating with the graying of our nation's population; malaria, which at any given moment affects 100 million persons; leprosy, a disease affecting 15 million people and on the increase; Parkinson's disease, an illness which afflicts approximately a million individuals in this country; ulcerative colitis, which affects 300,000 to 500,000 Americans and places them at 15 to 30 times the normal risk of colon cancer; premature birth, with its many adverse complications, that affects one of thirteen babies; and, drug addiction which is a national crisis.

Most recently, another national crisis has been addressed by the Primate Center Program - AIDS, an international epidemic which is estimated to infect 1.5 million Americans and up to 10 million people worldwide. With the discovery that the animal virus most similar to the human AIDS virus can only be studied in macaque monkeys, all seven Centers have been drawn into the national AIDS research effort. Some of the Centers have in a very short time increased their total research effort by as much as 50%. Efforts to understand how the virus induces disease and how to prevent it, vaccine studies and drug testing are well under way.

It is a testimony to the congressional wisdom of the 1960s that the Primate Centers Program exists and that it has been able to rapidly accommodate the AIDS effort. At the same time, the sheer magnitude of the AIDS program has brought into clear focus two problems that have been developing for the last 10 years. These are, first, the steady erosion of NIH support of core operations due to flat or decremental budgeting through a decade of mild but inexorable inflation; and, second, the inability of the Centers to provide space for 1980s' research in facilities built for the 1960s.

Pressures on the Primate Centers Program - In the past decade, the Centers have increasingly served as scientific resources for the biomedical community. Collectively, the seven Centers assist approximately 1,300 scientists who use nonhuman primates to investigate important human health problems. This number will likely increase because many university departments and research institutions have drastically reduced or eliminated the use of primates because of sharply rising costs. These institutions and their researchers are increasingly turning to the Primate Research Centers as places to carry out their work.

A second major unanticipated program of the Centers is the vast expansion in primate breeding colonies that has occurred to ensure that primates remain available to scientists throughout the nation. Now that so many species have become endangered or threatened with extinction or cannot be imported due to bans imposed by their native countries, the importance of this role of the Primate Research Centers cannot be overemphasized.

Finally, the biotechnology revolution is creating a vast new group of bioengineered products for the treatment of everything from heart disease to AIDS that will need to be studied and tested in nonhuman primates. The impact on Primate Research Centers from these new demands continues to grow. Even before the AIDS challenge, however, the Centers were having difficulty accommodating these valid and needed research efforts.

Funding Situation

Operating Funds Are Down - The ability of the Primate Research Centers to respond to these several areas of national concern depends on a stable operating budget. The non-AIDS core support to the Centers is the heart of the Program because it provides the primary source of funds to recruit and employ qualified researchers and technical personnel and to pay for the necessary and ever-increasing operating and maintenance costs. One objective of this testimony is to inform you that core support for the Primate Research Centers is decreasing during these times of increasing need for their unique resources.

In 1980, the seven centers were collectively approved for core grant funding through the NIH peer review process for $20.0 million; however, only

$16.2 million, or 81% of the approved level, was provided. For 1989, a funding level of $35.5 million was approved; actual funding will be about $25.8 million, or 73% of recommended levels. The gap between recommended levels of non-AIDS core support and actual funding has grown from $3.8 million/year to $9.7 million/year.

Furthermore, application of the Biomedical Research and Development Price Index to actual funding levels shows, in terms of 1980 dollars, that the appropriation for the direct costs of the Centers' core operations in 1989 is 20% less than it was in 1980. This erosion of funding occurred despite consistent recommendations for increased support by external peer review.

The negative funding trend was recently exacerbated by a 2.7% cut in the 1989 appropriation for the Primate Centers Program and a proposed 1.2% cut for 1990. Unless reversed, these cuts, coupled with inflation, will have devastating effects. Center scientific positions and programs will be closed as a result, and the ability to function as resources for other institutions will be compromised. If the Primate Centers Research Program is to fulfill its mission, this funding trend must be corrected.

Facilities Needs Are Up - Mention was made above about the roles the Centers are playing in the fight against AIDS. In order to safely conduct AIDS research, specialized facilities and equipment are required. To meet the need as rapidly as possible, the seven Centers have initiated research programs involving more than 200 new personnel (scientists, technicians, animal caretakers, etc.). They have allocated approximately 35,000 sq. ft. to laboratories and biohazard containment facilities for research and animals. In general, these allocations involve resources used previously for other programs.

In 1988, NIH made available AIDS infrastructure funds for which the seven centers competed; awards totaling $3.3 million were spread among five of the Centers. The infrastructure funds allowed modest expansion at these Centers. The need, however, is of a different order of magnitude. **It is estimated that the infrastructure development necessary for AIDS research and to accommodate the important programs dislocated by the rapid conversion to AIDS-related research will cost about $32 million. The needs vary from center to center, so funding for this purpose could be spread over a few years without compromising overall scientific efforts.**

Corrective Actions - We are fully aware of the fiscal problems facing our nation and appreciate the many competing, high priority needs that must be considered in making budgetary decisions. However, we submit that it is essential to prevent further deterioration of the unique resources of the national Primate Research Centers Program in order to meet current, pressing human health problems. To this end, we request that Congress appropriate $10 million more than was proposed for 1990 to provide non-AIDS core support for the Primate Research Centers Program at a level close to that recommended by the NIH peer review process.

Second, we urge Congress to establish a four-year appropriation plan providing $8 million per year to allow the centers to meet their now enormous commitment to AIDS research without jeopardizing strong, ongoing programs in the many other areas of biomedicine where primate research is equally essential. The funding should be designated for infrastructural development for AIDS research and other Center functions that may have been dislocated or blocked by crash renovations for AIDS. The funds allocated in 1988 were put to good use. However, more remains to be done if the Centers are to respond meaningfully to the many needs for their unique resources in this critical area.

The directors of the seven Regional Primate Research Centers hope that members of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies will take our request under serious consideration in the interest of solving some of our nation's most pressing health problems.

STATEMENT OF THE GERONTOLOGICAL SOCIETY OF AMERICA

Mr. Chairman, members of the Committee, The Gerontological Society of America appreciates the opportunity to submit to you our testimony on behalf of federal support for gerontological research, education, and training programs for the National Institute on Aging, the Administration on Aging, and the National Institute of Mental Health.

Each budget year brings tougher decisions for members of Congress. Difficult choices must be made about programs that meet important societal and individual needs. Significant budget increases, in general, are a thing of the past as agencies struggle to sustain current programs.

We are at a crossroads in charting our future course. The budget deficit must be brought under control. Yet, we must not lose sight of the long-term impact of the means we choose to accomplish this. The President and others in Congress have vowed not to increase taxes, so cuts must come from current programs. These "savings" may prove to be more costly in the long run. This is particularly true of investments in research.

As stated in "A Proposal for Fiscal Year 1989," prepared by The Ad Hoc Group for Medical Research Funding, "The solid foundation provided by Congressional support for medical research has enabled the United States not only to remain in the vanguard of scientific exploration in the life sciences, but also to eradicate or ameliorate diseases and illnesses that formerly killed or crippled millions around the world." The Group's report highlights some of the impressive payoffs that already have been realized from our investment. "Research," the report further states, "is our hope for the future, holding the promise for saving lives and improving the health of Americans." This hope, however, is threatened by the federal deficit crisis.

This testimony addresses three federal gerontological research programs, programs that take on increased significance with the expansion of the older population. The more we learn about what occurs as part of the aging process and what can be attributed to other factors, the better we understand the potential for improving the health of older people through disease prevention and health promotion.

In the past, the Gerontological Society has come before this subcommittee to request a greater federal investment in aging research. What is sometimes overlooked, however, is that research requires a complex system of support beyond the costs of the research itself. While it is essential to provide increasing opportunities to pursue research, it is equally important to recognize and provide the infrastructure and resources necessary to continue that research. These needs include facilities, equipment, and people.

This year, after carefully reviewing our priorities, we concluded that taking care of the infrastructure was our number one priority. Within that context, federal staffing reductions were viewed as the most critical issue needing Congressional attention. This does not mean that more research monies are not needed. It means that we have chosen to focus on staff reductions and other infrastructure issues because they threaten the effective management of the research program now in place.

The National Institute on Aging has experienced a 7 percent reduction in staff over the past five years, while at the same time its budget has jumped from $144 million in FY '85 to $222.9 million in FY '89. Since NIA is one of the newest and smallest NIH institutes, recent restrictions in full time equivalent (FTEs) levels have had a quicker and greater impact on normal and necessary staff development.

The National Institute of Mental Health has experienced a situation similar to that of the NIA. Its budget and responsibilities have grown over the past several years, while staff size has remained fairly constant.

The Administration on Aging also has been hard hit by staffing reductions. The last decade has seen a diminution in the number of professional staff on the order of 50 percent.

Until the staffing shortage problem is solved, it does not make sense to discuss new or bigger programs. And this problem is not limited to the programs addressed by this testimony, but threatens many other federal programs as well. The proposal developed by the Ad Hoc Group for Medical Research Funding calls attention to the continuing admininstrative stress caused by an inadequate number of full-time equivalent (FTEs) positions at the National Institutes of Health.

Another issue that threatens the ongoing research effort is the inadequate number of new scientists being trained for future research. Data from a number of sources, including the National Institute on Aging, the National Academy of Sciences (NAS), and the National Science Foundation (NSF), indicate a current shortage of certain types of scientists and suggest the likelihood of far greater shortages in the near future. Since the training period for becoming a fully qualified investigator is long, it is critical that trainees get into the pipeline as soon as possible to ensure a continual cadre of highly trained scientists.

The National Institute on Aging has taken several steps to attract talented scientists to the field, but still the Institute is faced with a crisis that threatens the mainstay of its training efforts--pre and postdoctoral training of basic scientists. The stipend level set by NIH is inadequate to attract the best and brightest to train for careers in research in aging.

Research training dollars at the National Institute of Mental Health are slated for a cutback under the Adminstration's budget at a time when two new and exciting initiatives are about to get underway--the National Plan for Schizophrenia Research and "Decade of the Brain."

Another issue, deterioration of this country's research facilities, is not one that is likely to gain much support from Congress due to the expense involved. However, if we do not begin soon with some investment, no matter how modest, to repair, renovate, and replace existing facilities (not constructing new ones) we will limit our ability to take advantage of future opportunities. The last NIH facilities grant was made in the 1960s.

An issue related to the research infrastructure is the immediate and urgent need to establish a tissue bank for the postmortem tissue from Alzheimer's disease patients and from aged normal controls. A major investment is being made to unravel the mysteries of the dreaded disease, but researchers are in desperate need of a central facility where they can obtain well characterized postmortem tissue. The timing of creating such a tissue bank is particularly critical as the availability of "uncontaminated" tissues declines due to more widespread experimental drug testing (e.g., tetrahydroaminoacridine).

The final issue to be addressed is the declining dollars available for competitive grants. A growing portion of research dollars is going to support noncompeting research awards and Congressionally mandated research programs in such areas as AIDs, Alzheimer's, and drugs, thus limiting support directed toward other new areas of inquiry. The reduction in competitive research dollars has been accompanied by a practice to "downward negotiate" the size of research project grants, which ultimately results in less research. These practices raise serious concerns because they threaten the emergence of new scientific opportunities and basic research.

While the National Institute on Aging has been spared the harsh cuts proposed for other Health and Human Services programs, the $7.3 million increase proposed by the Administration would barely keep NIA even with last year. Only 149 competing grants could be funded under the Administration's budget, a drop from 214 supported in FY '89. According to NIA figures, this total would allow NIA to fund only 19 percent of approved applications for new research grants, down from 30 percent in FY '89.

NIMH funded approximately 26 percent of approved grants in FY '89. This figure is likely to drop to 19.8 percent under the Administration's proposed budget.

Title IV under the Older Americans Act has been cut back substantially since the early 1980s. The program's budget has remained at about $24 million for the past eight years, a serious decline in real dollars. Perhaps more devastating has been the extensive earmarking by Congress that has virtually eliminated the valuable discretionary aspect of this program.

We must restore funding to maintain some measure of growth in the system to provide support for new people and new ideas.

In summary, The Gerontological Society of America supports

* the recommendations of the Ad Hoc Group for Medical Research Funding for an $8.4 billion budget for the National Institutes of Health and a $930 million budget for the Alcohol, Drug Abuse, and Mental Health Administration;

* increased staffing levels at NIA, AoA, and NIMH so that the programs at these agenceies can operate more effectively and efficiently;

* increased funding for education and training to ensure a continual cadre of highly trained scientists;

* increased support for basic research in the processes of aging;

* beginning to make an investment, even if at a modest level, to repair, renovate, and replace this country's research facilities;

* funds to assist the Alzheimer's research effort by creating a much needed national brain tissue bank ($2.5 million).

STATEMENT OF THE AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY

This testimony is submitted by the American College of Neuropsychopharmacology ("ACNP"), an interdisciplinary organization concerned with research about biological function in the central nervous system and its relationship to the causes and treatment of mental and addictive disorders. The ACNP membership constitutes the most active and distinguished group of scientists in the United States involved in the research areas covered by the three component Institutes of the Alcohol, Drug Abuse and Mental Health Administration ("ADAMHA").

The College submits that it is vital for the Congress of the United States to continue to support basic biomedical and behavioral research as an essential part of ADAMHA's program to address this nation's problems of alcoholism, drug abuse, and mental illness.

The federal government must continue to be the leading provider of significant funding of comprehensive research into the nature, treatment and prevention of the major mental illnesses, including the addictive disorders, if this nation is to continue to make advances in the quality of its health care system. Past appropriations by this Committee for basic research under the auspices of ADAMHA have been productive in saving lives, reducing health care costs, and providing insight into the chemical and biological bases of these serious disorders. Continued and even increased funding is needed to support recent research developments that are likely to lead to new and even better ways to diagnose, predict, treat, or prevent mental illness or addictive disorders. Several examples will suffice.

In the mental health area, ongoing studies with magnetic resonance imaging ("MRI") are examining and comparing the brains of people with disorders such as schizophrenia and autism with brains of normal individuals. Scientists have discovered that enlarged ventricles are a characteristic feature of schizophrenia, while in autistic patients a part of the cerebellum is abnormally small. Studies must continue to be funded to determine the implications of these differences in brain structure so that more effective treatment methods can be developed.

The development of lithium as a selective treatment for manic depressive disease has provided a means to control repeated attacks of emotional disorder, enabling thousands of Americans to be productive in their daily occupations and family responsibilities. It has been estimated to produce net savings in terms of days not lost from work, not spent in hospitalizations, and not lost from suicides that is more than 50 times the sums spent on research in the past decade alone, and the sums saved will continue to grow in the decades ahead.

The discovery that the brain makes natural chemical signals that account for the ability of anti-anxiety drugs such as benzodiazepine tranquilizers to act, has led to new molecular tests of the basis for anxiety and its treatment.

The ability to understand how viruses can affect the development of the brain and how neurons function in the developing adult brain is providing insight into dementia-like states from which AIDS patients suffer. This line of research may also provide insight into the causes of the signs of mental confusion in certain forms of schizophrenia, and establish the biological differences in the causes of different clinical forms of this disease.

The series of discoveries that establishes that the brain may make many other as yet undiscovered substances that act at sites that can be affected by addictive and abused drugs such as heroin, cocaine, smack, crack and PCP may well establish means to determine who may be vulnerable to these addictions and abuses and how they differ from relatively resistant individuals and families.

In the area of alcohol abuse, encouraging progress has been made in understanding the acute and chronic effects of alcohol on the nervous system. Research scientists are also discovering that genetic anomalies are present in individuals suffering from mental illness, drug addiction, and alcohol addiction. This information may pave the way to identifying genetic markers, so that prevention and treatment efforts can be more effectively targeted toward vulnerable individuals.

These are but a few examples of the many basic research efforts which have the potential to improve the quality of life for individuals afflicted with mental or addictive disorders and reduce the overall costs to society of these diseases.

The success of this basic research effort ultimately depends on adequate funding of each of its essential components -- that is, research project grants, training, equipment, and physical facilities. Within the overall spectrum of activities funded by the federal effort, there has been proportional underfunding in several critical elements which are essential to success of the overall effort. In particular, a greater proportion of the federal investment must be directed towards rebuilding the manpower pool of brain and behavioral scientists who can continue the momentum of the present research frontiers into the next century. Long term investments will be necessary to counteract the increasing loss of graduate and undergraduate students to the basic research effort. ACNP believes that improving funding predictability and increasing the duration of grants are two methods of bolstering the manpower recruitment effort.

Effective health sciences research also calls for state-of-the-art equipment and facilities. A significant proportion of the equipment that is now in use, however, needs either major upgrading or substantial repair in order for its users to continue to contribute as part of a competitive research effort.

The importance of maintaining all components of research at adequate levels is particularly important in the event of an unanticipated health emergency. The progress in developing drugs to combat the deadly AIDS virus has been as rapid as it has only because earlier studies in molecular biology had established a repository of knowledge about the immune system and how viruses interact with their host cells. The research tools and manpower were already on hand, ready to be channeled into the massive research programs established to combat AIDS. In order to successfully respond to future health care emergencies, each component part of the health research system must be maintained at appropriate levels of capacity.

The American College of Neuropsychopharmacology believes that the only realistic prospect of developing effective methods for the diagnosis, prevention and treatment of devastating mental health and addictive disorders depends on the discoveries that will flow from continued biomedical and behavioral research. ACNP urges that this Committee continue and even increase appropriations for the vitally important research programs of NIDA, NIMH and NIAAA.

STATEMENT OF KARST J. BESTEMAN, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG PROBLEMS ASSOCIATION

I appreciate this opportunity to present the views of the Alcohol and Drug Problems Association (ADPA) on behalf of its members and the Board of Directors. ADPA is an advocate for effective national policies and programs. ADPA has since its founding in 1949, been dedicated to the solution of alcohol and drug problems through the use of public health strategies and interventions. ADPA is composed of four councils. They are: the state council, the agency council, the individual councils, and the council of state associations. ADPA is the most comprehensive and broadly based membership organization in the addiction field. The Association has three priority functions: in the development of effective public policy, the education and training of professionals, and the communication of information to our members.

The fiscal year 1990 budget proposed by the Administration which is before the Committee is an important document. It is the manifestation of the commitment made with the passage of P.L. 100-690: "The Anti-Drug Abuse Act of 1988." The Congress and the Administration hailed this law as a first step in a long difficult process of reducing the suffering, death and destruction caused by and associated with the addictions.

The Administration's Fiscal Year 1990 proposals to fund alcohol and drug abuse activities for prevention, training treatment and research are not adequate to effectively address these problems or to support the programs essential to solving them.

The nation needs national leadership and support for an addictions treatment system capable of effectively responding to the requests for help from addicted people.

Mr. Chairman, it is the opinion of this association that the Congress will be making a major contribution to the improved health status of the nation by aggressively and adequately funding the alcohol and drug abuse authorities which commit the federal government to action in solving the problems of the addictions. To that end we urge you to appropriate the following amounts in lieu of the Administration's proposals:

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA) RESEARCH
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY' 90	Our Proposal FY '90
Research (Ex./Intramural)	$102.8	$109.4	$121.2	$138.7
Demo./Homeless	4.5	0*	4.8	17.0*
Res. Mgmt. & Support	9.2	10.3	10.3	11.6
TOTAL	$116.5	119.7	136.3	167.3

The NIAAA is the lead federal agency responsible for reducing the health, social and economic consequences of alcohol abuse and alcoholism in the United States. Committed to the development of a strong knowledge base, the institute supports a comprehensive program of extramural and intramural research aimed at developing effective treatment and prevention strategies.

The purpose of the NIAAA research program is to improve the treatment and prevention of alcoholism and alcohol-related problems.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) RESEARCH
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY' 90	Our Proposal FY '90
Research (Ex./Intramural)	$146.3	$154.9	$160.2	$172.3
Demo./Homeless	7.0	7.0	7.4	10.0
Res. Mgmt. & Support	15.0	16.4	16.4	18.4
TOTAL	$168.3	178.3	184.0	200.7

The National Institute on Drug Abuse (NIDA) provides leadership for a national program of research on drug abuse. Supporting basic research, clinical and epidemiologic studies, demonstration and education projects, the NIDA addresses pressing questions about the causes, consequences, incidence and prevalence, prevention and treatment of drug abuse through its intramural and extramural research programs.

The incidence of illicit drug use and the number of new drugs being used are unprecedented. Faced with what is clearly a drug epidemic, the need for research has never been greater. Responding to this alarming situation, the NIDA has identified several research priorities requiring added attention and maximum resources which include: the development of new treatment approaches pharmacology agents; prevention strategies; vulnerability to addiction; and treatment evaluation.

In the last three years, the Institute has supported significant research to improve our ability to treat dependent persons. However, special emphasis must be given to the development of new pharmacologic agents to aid in the treatment of cocaine, cocaine derivatives, and PCP.

NATIONAL INSTITUTE FOR DRUG ABUSE
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

AIDS
(dollars in millions)

	Estimate FY '89	President FY '89	Current Services FY '89	Our Proposal FY '90
NIDA	120.5	139.9	139.9	151.4
NIAAA	6.1	8.3	8.3	8.9

NIDA and NIAAA must play a major role in the Government's war against the AIDS epidemic because of the growing numbers of IV drug abusers who contract AIDS and transmit the virus to sexual partners and children. The nation has now recognized that the battle against the spread of AIDS will be fought primarily on the drug abuse front.

This proposal will enable the institutes to research effective prevention strategies, design innovative outreach programs to drug users and demonstrate model treatment services for IVDU's and other addicted individuals.

Of the approximately $151 million requested for NIDA, we propose that approximately $52 million be used for extramural and intramural research.

OFFICE FOR SUBSTANCE ABUSE PREVENTION
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY '90	Our Proposal FY '90
Demonstration	56.1	57.1	60.6	114.3
Training	5.0	5.3	5.4	27.3
Program Management/ Support	8.7	9.8	10.9	12.7
TOTAL	69.8	72.3	77.0	154.3

The Office for Substance Abuse Prevention (OSAP) was created by the Anti-Drug Abuse Act of 1986 to consolidate Department prevention efforts relating to alcohol and other drugs of abuse as well as to develop new prevention initiatives with particular emphasis on high risk youth.

The Anti-Drug Acto of 1988 significantly expanded the scope and functions of OSAP, establishing it as a fourth separate entity within ADAMHA, increasing its responsibilities to include four new programs, and broadening its mandate toward a more community-wide focus. The aim is to establish a productive comprehensive program that will address the alcohol and other drug abuse prevention needs of the Nation.

Demonstration Project:

Of the amount appropriated for OSAP in FY 1989, 56.1 million was mandated for demonstration projects. Only modest numbers of the new programs will be developed. For example, 25 new programs will be funded for pregnant addicted women and/or postpartum women and infants. The birth of addicted babies to women with drug problems is a serious national problem. We urge the appropriation of 5.5 million in new monies to expand these efforts.

In recognition of the fact that substance abuse prevention is a long range comprehensive process, the Administration requested 35 million to initiate community partnership grants for drug abuse prevention. This proposed initiative would demonstrate the effectiveness of community coalitions of organizations representing youth, parents, health professionals, clergy, comprehensive prevention programs. We support the recommendation of the Administration and urge the appropriation of $35 million to fund this new initiative.

Training:

OSAP has the legislative mandate to provide leadership in support of community program development. There is a great need to develop a national training system. National needs assessment, training curricula, organizational development, replication of program models, social policy action, and continuing education opportunities would be the major components of this system.

We urge an appropriation of 18 million to support state training activities.

Program Management and Support:

We recognize that to effectively mange these expanded programs, provide technical assistance, and operate the Alcohol and Drug Abuse Clearinghouse (which received over 12,000 requests for information/month) and design the new grant evaluation projects, there is a need for more federal personnel. We recommend an adequate increase to support these activities.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT
(dollars in millions)

	Estimate FY '89	President FY '90	Current Services FY '90	Our Proposals FY '90
ADMS Block Grant	$805.6	$834.6	$800	$1600

The Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant is the foundation of funding for alcohol, other drug abuse and community mental health services, helping to forge a partnership among federal, state and community services, was expanded and restructured as part of the Omnibus Anti-Drug Act of 1988 (P.L. 100-690). The new ADMS Block Grant consists of the previous program (alcohol, other drug abuse and mental health services), the Emergency Alcohol and Drug Treatment Block Grant, and a new emphasis on increasing treatment to intravenous drug users to reduce the transmission of AIDS.

ADPA recommends that the Alcohol, Drug Abuse and Mental Health Block Grant be funded at $1.6 billion for FY 1990 to provide for an increased capacity to address the need for alcohol and other drug prevention and treatment. In order to assure the States' ability to effectively plan for and manage Federal funds, appropriations levels should: 1) reflect a long term commitment by the Federal government to provide a stable funding base for the development of comprehensive programs based on the specific and unique needs of each State; 2) ensure that monies to all State are increased and that no State suffer reductions or cuts in monies or existing services, specifically including continuation of services established for the reduction of waiting lists; and 3) reflect the intent of Congress and the Administration by fully funding the recently enacted Anti-Drug Bill (P.L. 100-690).

STATEMENT OF PHYLLIS R. MAGRAB, PH.D., GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER

Thank you for the opportunity to submit budget recommendations on behalf of vulnerable individuals in our society who cannot speak for themselves: seriously emotionally disturbed children and adolescents. Specifically:

1. The FY 1990 NIMH clinical training budget should be increased from $12.8 to $26 million.

2. At least $5 million of the increase should be earmarked for preservice training for new professionals who will provide services to seriously emotionally disturbed children and adolescents.

3. Congress should mandate a study on mental health personnel shortages for priority populations including children, experienced at the present time and estimated for 1995, 2000, and 2010.

On May 18-20, 1988, I had the privilege of chairing a National Conference on Clinical Training in Psychology: Improving Psychological Services for Children and Adolescents with Severe Mental Disorders (*). Participants included leaders in clinical child psychology and related areas such as pediatric psychology, school psychology, and applied developmental psychology, state and community children's program directors, and several graduate students. The conference constituted an excellent representation of professionals in child psychology who give service to, and provide training to others, for services to emotionally disturbed children and adolescents. I wish to quote the major recommendations from the Conference:

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* This conference was conducted by the Georgetown University Child Development Center's Child and Adolescent Service System Program's Technical Assistance Program. The full report of Conference Recommendations and Proceedings is to be published and distributed in June, 1989.

"Mental Health Service Needs of Children Adolescents, and Families: Implications for Training

"1. As the 1987 Office of Technology Assessment study on Mental Health Services for Children and many other studies have pointed out, millions of children and adolescents with severe mental disorders still do not receive adequate services.

"2. A major reason continues to be the shortage of well trained personnel.

"3. Minority children and adolescents are particularly underserved.

"Recommendations to NIMH for Clinical Training Policy: NIMH should continue to exert nation leadership to:

1. Attract more students in clinical child psychology and related areas to seek careers in the public sector to provide services to children, adolescents, and families; have special incentives for minority students. Specifically:

- Continue trainee stipends with payback to assure that trainees begin their careers in the public sector.
- Create special federal-state incentives to draw students who are already experienced in state/community programs.

2. Strengthen linkages between state/community service settings and academic/internship training programs; using the Children and Adolescent Service Systems Program (CASSP) model, stimulate stronger linkages by new, creative, flexible funding.

3. Encourage academic/internship faculty to develop their skills and curricula in the latest community-based services and clinical research; create academic-state exchange programs; special incentives for minority faculty.

4. Restore greater integrity and confidence in the clinical training grants process by providing pre-1981 staffing for purposes of consultation/ technical assistance. Standing review committees should be restored to assure the higher quality of review that is possible with ad hoc committees.

5. Like the Congressionally-mandated 1987 study of personnel for the aging, there should be greater systematic study to assess the numbers and kinds of trained personnel, including but not limited to clinical child psychologists, to render quality services to children and adolescents with severe mental disorders.

6. High quality training for children and adolescents with severe mental disorders should not be narrowly defined, but should be construed to include training for services to the seriously emotionally disturbed (SED), as in the CASSP definition, but also to the less seriously emotionally disturbed, and even prevention programs."

Besides our national conference on training for children, two parallel national training conferences were also held last spring: Seriously Mentally Ill, at the University of Houston and Training of Racial/Ethnic Minority Students, at UCLA. In summary, over 140 national leaders in psychology in these priority populations participated last spring to recommend program policies and budget priorities to NIMH. On June 13, 1988, representatives of the three conferences met and agreed upon the following recommendations to NIMH:

"The conferences agreed with NIMH that seriously mentally ill adults, children, and adolescents constitute underserved priority populations, and that racial/ethnic minority and disadvantaged students need special support. However, racial/ethnic minorities, soon to be one quarter of the U.S. population, constitute another underserved priority population which NIMH should acknowledge. Indeed, this fact is documented not only by the last President's Commission on Mental Health, but also by many other reports, including NIMH's 1987 Conference on Minority Mental Health Services Research.

"A major reason why millions with serious mental disorders in the above priority populations do not receive adequate services continues to be a shortage of well trained personnel, including psychologists.

"Therefore, all three conferences were in agreement on the following recommendations:

1. The three conferences recommended that very high priority be given to the restoration of Clinical Training Grants which include Trainee Stipends; these grants should follow the Community Support Program (CSP) or Child and Adolescent Service Systems Program (CASSP) model, with academic-state/community collaboration and should support trainees at least at three levels: Academic doctoral, predoctoral internships, and postdoctoral fellowships. Academic doctoral support is critical to the development of mental health professionals qualified to respond to the needs of the underserved priority populations. As one proceeds from predoctoral academic training, to predoctoral internship, to postdoctoral fellowship support, one may expect an increasing degree of specialization to provide services for one or more priority populations.

2. The three conferences ranked Faculty Development as high in priority for funding, with the stipulation that such new faculty development awards be much more flexible than the present Individual Faculty Scholar Awards. Specifically, such awards should permit short-term as well as long-term training, institutional training grants as well as individual awards, be available to internship supervisors as well as academic faculty, encourage exchange of academic faculty and state/community staff, etc.

3. Also, the three conferences ranked Model Curriculum Research and Development, Continuing Education, and Model State-Academic Interdisciplinary Linkage Programs, as deserving of some modest level of funding."

Shockingly, at the same time last spring when our three conferences were making important recommendations for the NIMH clinical training program directions, Congress cut NIMH's budget by 25%, from $16.8 million in FY1988 to $12.8 million in FY1989. The result is an emasculated program. In FY1986 when the total clinical training budget was $20 million, NIMH allocated $9.9 million to support about 200 training programs in nursing, psychiatry, psychology, and social work, including 81 grants totalling $3.3 million specifically for children. The total grants supported about 500 student trainees on stipends with payback requirements.

With the total FY1989 budget reduced to $12.8 million, NIMH plans to allocate about $4.5 million to fund 50 training grants supporting an estimated 220 trainees. It is further estimated that only 10 of these grants totalling $1 million will specifically be to train about 40 service providers for disturbed children.

Several problems demand Congress's immediate attention and possible correction:

First, the total NIMH clinical training budget for FY1990 should be increased to $26 million, as recommended by the Coalition for Mental Health. Last year in reducing the FY1989 budget for NIMH clinical training, the House Appropriations Committee observed that it was increasing the NIMH research budget, seeming to imply that research and clinical training are equivalent. Unfortunately, this statement was a non sequitur, as NIMH research is not equivalent to NIMH clinical training. While research may result in a future services breakthrough, clinical training is absolutely necessary to address immediate gaps in services because of shortages in trained personnel.

Second, at least $5 million of the increase should be earmarked for preservice training for new professionals who will provide services to seriously emotionally disturbed children and adolescents. As the preceding figures illustrate, a small portion of the clinical training budget ultimately goes to support training for children's services. And the situation is deteriorating. Between FY1986 and estimates for FY1989, while the total NIMH clinical training budget is decreasing by 36%, the number of child training grants is projected to decrease by 88%, and the level of funding for child grants is projected to decrease by 70%.

In FY1987, the House Appropriations Committee recommended reduction of $10 million less than the Senate Appropriations Committee's recommendation of $20 million (a compromise of $15 million was reached). The House Report noted that "priority should be given to training systems which produce professionals to service children and the aged" (House Appropriations Report, July 24, 1986, Mr. Natcher, (p. 92)). Unfortunately, this Congressional mandate was not followed. In FY1987, more than half of the present child clinical training grants terminated without a chance for continuation.

Third. Congress should commission an on-going, systematic study on mental health personnel shortages in priority areas, including children, experienced at the present time and estimated for 1995, 2000, and 2010. Congress has been very interested in the actual size of the present pool of professionals who work with children, and also the projected need for such professionals. They commissioned the 1986 study, Children's Mental Health: Problems and Services, by the Office of Technology Assessment (OTA). This report states, "there are approximately 3,000 child psychiatrists, 5,000 clinical child psychologists, 7,000 child and family-oriented social workers, and 1,000 child/family-oriented mental health nurses... Estimates of the numbers of professionals needed have consistently been much higher" (p. 141).

The OTA report does not, however, specify exactly how many professionals are needed to work with children. In each of the four disciplines, child psychiatry, child/family-oriented psychiatric nursing, clinical child psychology, and mental health social workers specializing in child mental health, a case may be made for how many professionals are needed. In spite of the merits of such analyses, there is a great need for a careful data-based study of more exact numbers of child mental health professionals needed. Such a study in the field of personnel needs in health for the elderly in 2020, was mandated by Congress in 1987. Congress should mandate a similar study of shortages of trained personnel for mental health services, including disturbed children.

STATEMENT OF DALE L. JOHNSON, PH.D., THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. Chairman and members of the committee. My name is Dr. Dale L. Johnson, and I am a professor of psychology at the University of Houston. I am pleased to be here today to testify on behalf of the 87,000 members of the American Psychological Association. I am also a member of the board of the National Alliance for the Mentally Ill, an organization comprised of 80,000 relatives of individuals who have serious mental illnesses.

The point of my testimony is that people who suffer from such serious mental illnesses as schizophrenia, manic depression, and major depression, are not receiving the treatment and rehabilitation that they need and deserve. They are not adequately treated because mental health professionals still are not being trained to provide the most effective services available. Indeed, within the profession of psychology, hardly any graduate training programs offer specialty training in working with this large group of people. The result is that out-of-date treatments are being used and individuals with mental illnesses are deprived of a right to recover and rejoin the community. We now have available to us, thanks largely to research supported in the past by NIMH, psychosocial treatment and rehabilitation methods that we know are capable of restoring large numbers of persons with mental illnesses to the community and often to productive employment. These modern methods are not being as widely used as they should be because graduate training programs do not include sufficient consideration of the seriously mentally ill in their curricula, faculty have not developed an interest in the area, and students have not learned that this is an interesting and rewarding field for professional development.

In early 1988, a conference was held at the University of Houston on the problems of improving training for work with serious mental illnesses. The conference was attended by 45 leading educators and researchers in psychology and other mental health professions. Their recommendations are attached and I would like to enter them into this testimony for your consideration. Please note that the conference participants gave serious thought to the matter of providing adequate training within the budgetary constraints that currently affect all legislation. A major part of their recommendations is that support for training be a joint responsibility of national and state governments. The recommendations are workable and urgently in need of implementation. The first step toward that implementation is an increase in the NIMH budget for Clinical Training. We strongly support funding at the $26,000,000 level for fiscal year 1990. Thank you.

Introduction

Evidence from all sources indicates that persons with serious mental illnesses (SMI) are not being served adequately. Psychologists have contributed much to the improved well-being of this group of people, and can contribute more, but at present students have little exposure to or experience in working with this population. In general, they are unaware of the new treatment and rehabilitative methods that have been developed. A major part of the problem is that faculty have been trained in older models of treatment and have little interest in this area. They, too, appear to be unaware of developments in the area.

Training should include exposure to the field as defined by the Community Support System (CSS) components for all graduate students in clinical and counseling psychology, experience in working with the population for a substantial number, and development of expert knowledge by a group of students who wish to specialize in the area.

In addition to the on-going need for more personnel in this are, new NIMH programs, the Schizophrenia Initiative and the D/ART program, require appropriately trained psychologists for full implementation.

It is, therefore, of highest importance that this be identified as a priority training area and that it should be supported with sufficient funds to bring enough well-trained psychologists into the field to make a major difference in how services are delivered.

Recommendations

1. Faculty and students need to be aware of the body of knowledge that now exists and continues to develop in this area. NIMH should facilitate this process by assembling this knowledge and informing faculty and students about through periodically up-dated bibliographies and computerized information systems. This would include information about model programs and model curricula.

2. As it is vital that all clinical and counseling psychology graduate students have some exposure to the area and that this will occur only if faculty are knowlegeable and interested it is recommmended that faculty development be promoted by NIMH by providing resources for sabbaticals or summer conference training in appropriate settings.

3. In order to develop higher levels of expert knowledge in the smaller group of students who wish to specialize in the area it is recommended that NIMH provide graduate stipends for students in programs that offer specialized training. These stipends should have appropriate pay-back requirements.

4. It is further recommended that the development of expert knowledge level students should be fostered by NIMH through the provision of support for two year internship programs (one year pre-doctoral and one year post-doctoral), again, with pay-back requirements.

5. NIMH should develop regional training-research-treatment facilities to provide training sites for faculty and students in state-of-the-art methods for the treatment and rehabilitation of persons with serious mental illnesses.

6. In order to extend training activities as widely as possible, NIMH should promote collaboration of state and local agencies (public and non-profit) with universities in training. It is recommended that NIMH take the lead in funding the training of doctoral level students and states take responsibility for funding training of MA level psychologists, but that at all levels collaborative efforts be encouraged.

7. It is also recommened that NIMH encourage the involvement of consumers and their families in training of all kinds.

8. Minorities make up a substantial part of the population of persons with serious mental illnesses and NIMH should encourage the recruitment of minority students and faculty to work with this group.

9. It is recommended that standing committees be formed to review training grant recommendations and that these recommendations be reviewed by committees that are interdisciplinary in make-up formed to hear recommendations for training to work with specific priority populations. Equitable funding for each discipline is also recommended.

Conference Procedures

Recommendations were developed at a conference convened at the University of Houston on April 6-8, 1988. The participants included 45 psychologists and other mental health professionals who are involved in training students and in carrying out clinical services for persons with serious mental illnesses. The summary of the recommendations was prepared by the conference host, Dale L. Johnson, Ph.D.

STATEMENT OF B.R. (PETE) KENNEMER, CHAIRMAN, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

MR. CHAIRMAN, MY NAME IS B.R. (PETE) KENNEMER, EXECUTIVE DIRECTOR OF THE WESTERN ARKANSAS COUNSELING AND GUIDANCE CENTER IN FORT SMITH, ARKANSAS. IN ADDITION TO SERVING ON THE NCCMHC BOARD OF DIRECTORS, I AM ALSO CHAIRMAN OF THE PUBLIC POLICY COMMITTEE. I WOULD LIKE TO TAKE THIS OPPORTUNITY TO PRESENT MY ORGANIZATION'S VIEWS REGARDING FY 1990 FUNDING OF ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PROGRAMS UNDER THE JURISDICTION OF THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION.

THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS REPRESENTS MORE THAN 600 COMMUNITY MENTAL HEALTH PROGRAMS COMPRISING SOME 62,000 STAFF AND BOARD MEMBERS NATIONWIDE TO SERVE SOME FIVE MILLION PEOPLE THROUGHOUT THE COUNTRY. THESE PROGRAMS PROVIDE NEEDED MENTAL HEALTH, ALCOHOLISM AND DRUG ABUSE SERVICES TO PEOPLE OF ALL AGES AND DISABILITY GROUPS. COMMUNITY MENTAL HEALTH PROGRAMS ARE DESIGNED TO PROVIDE COMPREHENSIVE TREATMENT FOR THE MENTALLY ILL AT THE LOCAL LEVEL ENCOMPASSING SUCH SERVICES AS OUTPATIENT, INPATIENT, EMERGENCY, PARTIAL CARE, PSYCHOSOCIAL REHABILITATION, RESIDENTIAL, CASE MANAGEMENT, AND CONSULTATION AND EDUCATION. THROUGH PROGRAMS SUCH AS THESE, A MAJORITY OF OUR NATION'S CITIZENS, INCLUDING THE SERIOUSLY MENTALLY ILL, CHILDREN AND ADOLESCENTS, RESIDENTS OF RURAL COMMUNITIES AND THE ELDERLY, HAVE ACCESS TO MENTAL HEALTH SERVICES THAT WOULD NOT OTHERWISE BE AVAILABLE TO THEM IN A SETTING THAT OFFERS CLIENTS AN OPPORTUNITY TO REMAIN IN THE COMMUNITY WITH FAMILY AND FRIENDS AT A LOWER COST THAN INSTITUTIONAL CARE.

REVENUES FOR COMMUNITY MENTAL HEALTH SERVICES FLOW FROM MANY SOURCES, INCLUDING THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT, STATE GOVERNMENTS, LOCAL GOVERNMENTS, MEDICARE, MEDICAID, PRIVATE INSURERS, PATIENT FEES, AND PHILANTHROPIC CONTRIBUTIONS.

THE NATIONAL COUNCIL HAS JOINED WITH 51 OTHER NATIONAL ORGANIZATIONS IN SUPPORT OF A PACKAGE OF FUNDING RECOMMENDATIONS DIRECTED AT SERVICES, RESEARCH AND TRAINING PROGRAMS UNDER THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION. THIS COALITION OF GROUPS IS DEEPLY CONCERNED ABOUT THE INADEQUACY OF THE ADMINISTRATION'S PROPOSED FY 1990 BUDGET FOR THE VARIOUS PROGRAMS WITHIN ADAMHA. HISTORICALLY, FUNDING FOR ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICE PROGRAMS HAVE BEEN WOEFULLY INADEQUATE GIVEN THE

TREMENDOUS DEMANDS PLACED UPON COMMUNITY AGENCIES ACROSS THE COUNTRY.

AS YOU KNOW MR. CHAIRMAN, THE PRESIDENT INCLUDED FUNDING FOR ADAMHA PROGRAMS WITHIN HIS PROPOSAL FOR A "FLEXIBLE FREEZE" FOR FY 1990. UNDER THE "FLEXIBLE FREEZE" FUNDING OF SOME PROGRAMS MIGHT BE INCREASED, BUT ONLY IF COMMENSURATE REDUCTIONS OCCUR IN OTHERS TO MEET THE OVERALL FY 1990 OUTLAY TARGET. IN THIS AND OTHER PROGRAMS FROZEN AS PART OF THE ADMINISTRATION'S PROPOSAL, A CUT WOULD BE REQUIRED OF APPROXIMATELY 10 TO 15 PERCENT BELOW THE AMOUNT NEEDED TO MAINTAIN FY 1989 SERVICE LEVELS IN FY 1990 (ADJUSTED FOR INLATION). WHILE PRESIDENT BUSH DID PROPOSE AN INCREASE FOR SUBSTANCE ABUSE SERVICES, SPECIFIC AMOUNTS WERE NOT DISCLOSED IN HIS BUDGET MESSAGE.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH (ADM) BLOCK GRANT IS THE FOUNDATION OF FUNDING FOR ALCOHOL AND DRUG ABUSE AND COMMUNITY MENTAL HEALTH SERVICES, HELPING TO FORGE A PARTNERSHIP AMONG FEDERAL, STATE AND COMMUNITY-LEVEL PROVIDERS. THE ADM BLOCK GRANT, ESTABLISHED IN 1981 TO FINANCE COMMUNITY SERVICES, WAS EXPANDED AND RESTRUCTURED AS PART OF THE OMNIBUS ANTI-DRUG ABUSE ACT OF 1988 (P.L. 100-690). THE NEW ADM BLOCK GRANT CONSISTS OF THE PREVIOUS PROGRAM (MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES), THE EMERGENCY DRUG TREATMENT BLOCK GRANT, AND A NEW PROGRAM TO REDUCE THE TRANSMISSION OF AIDS BY USERS OF ILLEGAL INTRAVENEOUS DRUGS. IN FY 1989, $805.6 MILLION WAS MADE AVAILABLE FOR THESE PURPOSES WITH $246 MILLION FOR MENTAL HEALTH SERVICES. UNDER THE NEW LAW, STATES ARE REQUIRED TO INCREASE SPENDING ON NEW COMMUNITY MENTAL HEALTH SERVICES SO THAT BY FY 1991 AT LEAST 55 PERCENT OF MENTAL HEALTH FUNDS ARE DEVOTED TO SERVICES NOT AVAILABLE ON OCTOBER 1, 1988. THE NEW LAW ALTERS THE ALLOTMENT FORMULA USED TO DISTRIBUTE FUNDS TO THE STATES BASED ON POPULATION AND PER CAPITA INCOME.

THE ADM BLOCK GRANT PLACES HIGH PRIORITY ON THE EXPANSION OF BOTH COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES AND MANDATES THE DEVELOPMENT OF SERVICES TO REDUCE THE TRANSMISSION OF HIV INFECTION BY USERS OF ILLEGAL INTRAVENOUS DRUGS. IN RECOGNITION OF THESE BOLD NEW CONGRESSIONAL INITIATIVES, NCCMHC RECOMMENDS $918.6 MILLION TO CONTINUE THE EXPANSION BEGUN LAST YEAR. THIS REPRESENTS A 10 PERCENT INCREASE OVER THE CURRENT SERVICES ESTIMATE OF $834.6 MILLION. THE ADDITIONAL FUNDS ARE NECESSARY TO INCREASE THE FEDERAL COMMITMENT TO THE "WAR ON DRUGS" AND MEET THE NEEDS OF HOMELESS INDIVIDUALS WITH MENTAL ILLNESS. NCCMHC REQUESTS ADDITIONAL FUNDS FOR THOSE

STATES THAT MAY OTHERWISE LOSE FUNDING IN FY 1990 DUE TO CHANGES IN THE ALLOCATION FORMULA. IT WILL ALSO PREVENT PROGRAM TERMINATIONS THAT WILL OCCUR IN EXISTING SERVICES BECAUSE OF THE REQUIREMENT WHICH SETS ASIDE A MAJORITY OF CURRENT MENTAL HEALTH FUNDS FOR NEW SERVICES.

P.L. 100-690 REQUIRES THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA) TO SET ASIDE A MINIMUM OF FIVE PERCENT OF THE ENTIRE BLOCK GRANT (ALLOWING UP TO 15 PERCENT OF THE TOTAL) FOR NATIONAL LEVEL ACTIVITIES SUCH AS DATA COLLECTION. IN FY 1989, ADAMHA TOOK ITS STATUTORY MINIMUM OF FIVE PERCENT. HOWEVER, ADAMHA HAS STATED ITS DESIRE TO TAKE "APPROXIMATELY SEVEN PERCENT" IN FY 1990. THESE FEDERAL SET-ASIDES PLACE ADDITIONAL STRESS ON CURRENT SERVICES.

MR. CHAIRMAN, NO DISCUSSION OF FY 1990 FUNDING FOR THE ADM BLOCK GRANT CAN TAKE PLACE WITHOUT SOME MENTION OF THE CURRENT SITUATION WITH RESPECT TO THE DRAW DOWN OF FY 1989 FUNDS TO THE STATES. AS HAS BEEN WIDELY REPORTED, $777 MILLION IN FY 1989 FUNDING FOR MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS UNDER THE BLOCK GRANT REMAINS UNSPENT. THIS INCLUDES $158 MILLION OF THE $644 MILLION APPROPRIATED FOR FY 1988 AND $619 OF THE $806 MILLION FOR THE CURRENT FISCAL YEAR. THE INABILITY OF STATES TO DRAW DOWN FUNDS IN A MORE EXPEDITIOUS MANNER IS OF GREAT CONCERN TO THE NATIONAL COUNCIL. THE REASONS MOST OFTEN CITED INCLUDE A LACK OF STATE PROGRAMS SPECIFICALLY DESIGNED TO MEET FEDERAL GUIDELINES AND THE DELAY IN ENACTING AND IMPLEMENTING THE 1988 AMENDMENTS WHICH WERE PART OF THE OMNIBUS DRUG BILL.

MR. CHAIRMAN, LET ME STRESS THAT I AM NOT HERE TODAY TO JUSTIFY OR EXPLAIN WHY STATES HAVE FAILED TO DRAW DOWN THESE FUNDS. WHAT I DO WANT YOU TO KNOW IS THAT IN VIRTUALLY EVERY COMMUNITY IN THIS NATION, WE PROVIDERS ARE CONSTANTLY FACED WITH THE POSSIBILITY OF HAVING TO DENY NECESSARY TREATMENT TO DESPERATELY ILL PEOPLE BECAUSE OF OUR DWINDLING RESOURCES TO SERVE THOSE WHO CAN NOT PAY FOR SERVICES. PLEASE DO NOT CONCLUDE THAT BECAUSE A STATE HAS NOT DRAWN DOWN ITS FEDERAL FUNDS THAT THE COMMUNITIES IN THAT STATE ARE IN ANY THING BUT DESPARATE NEED OF THESE FUNDS.

IT IS IMPORTANT TO RECOGNIZE THAT P.L. 100-690 IS THE FIRST REALLY MAJOR CHANGE IN THE AUTHORIZATION STATUTE FOR THE ADM BLOCK GRANT IN THE 1980s. ALREADY IN THE 101ST CONGRESS, BOTH THE HOUSE AND SENATE HAVE PASSED TECHNICAL CORRECTION BILLS TO THE 1988 AMENDMENTS. INCLUDED IN THE SENATE BILL IS A

FORMULA CHANGE PROPOSED BY SENATORS BUMPERS AND HOLLINGS (BOTH MEMBERS OF THIS SUBCOMMITTEE) DESIGNED TO ALTER THE DISTRIBUTION FORMULA WITH RESPECT TO STATE-TO-STATE ALLOCATIONS. THE SENATE AMENDMENT CHANGES THE NEW "URBANIZATION" FACTOR FROM 40 TO 20 PERCENT WHILE MAKING PERMANENT THE REQUIREMENT FOR THE "FIRST" $330 MILLION TO BE ALLOCATED ON THE BASIS OF THE OLD FORMULA.

MR. CHAIRMAN, NCCMHC STRONGLY SUPPORTS EFFORTS IN CONGRESS TO IMPROVE THE CURRENT FORMULA TO ADEQUATELY PROJECT AGAINST CUTS IN CURRENT PROGRAMS. IN PARTICULAR, WE ARE VERY INTERESTED IN SEEKING WAYS TO CORRECT INEQUITIES IN THE INTERSTATE ALLOCATION FORMULA AS THEY RELATE TO RURAL STATES. WE SUPPORT THESE CHANGES AND FEEL THAT THEY SERVE RURAL STATES MORE EQUITABLY WITHOUT ERODING ANY CURRENT FUNDING LEVELS IN LARGER STATES.

MR. CHAIRMAN, I WOULD LIKE TO MENTION THE NATIONAL INSTITUTE OF MENTAL HEALTH'S SERVICES DEMONSTRATION AUTHORITY. THIS COMMITTEE HAS BEEN VERY SUPPORTIVE OF THIS PROGRAM IN THE PAST. THE NIMH COMMUNITY SUPPORT PROGRAM AND DEMONSTRATIONS FOR PERSONS WHO ARE HOMELESS AND MENTALLY ILL HAVE BEEN MAJOR CONTRIBUTORS TO THE FIELD IN EXPANDING NEW SERVICE TECHNOLOGIES TO OUR NATION'S COMMUNITIES. THE NATIONAL COUNCIL WOULD LIKE TO SEE THIS PROGRAM EXPANDED TO SUPPORT THE NEW RURAL MENTAL HEALTH DEMONSTRATION PROGRAM WHICH HAS BEEN PROPOSED BY THIS CONGRESS. WE SUPPORT THE ADDITION OF $10 MILLION TO THE NIMH DEMONSTRATION ACCOUNT TO ASSIST STATES AND COMMUNITIES IN MEETING THE IMMEDIATE MENTAL HEALTH NEEDS OF RURAL RESIDENTS CURRENTLY AFFECTED BY THE FARM CRISIS.

IN CLOSING MR. CHAIRMAN, WE FULLY RECOGNIZE THE DIFFICULT CHOICES THE SUBCOMMITTEE WILL HAVE TO MAKE REGARDING FUNDING LEVELS FOR PROGRAMS UNDER YOUR COMMITTEE'S JURISDICTION. HOWEVER, WE STRONGLY BELIEVE THAT OUR COALITION'S RECOMMENDATIONS ARE RESPONSIBLE AND EXTREMELY WELL JUSTIFIED AND WE RESPECTFULLY URGE THE SUBCOMMITTEE'S SUPPORT.

THANK YOU FOR GIVING ME THE OPPORTUNITY TO PRESENT THE NATIONAL COUNCIL'S VIEWS ON FY 1990 FUNDING FOR THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION.

STATEMENT OF RODOLFO BALLI SANCHEZ, NATIONAL HISPANIC FAMILY AGAINST DRUG ABUSE

Mr. Chairman and members of the Subcommittee, I am Rodolfo Balli Sanchez, chairman of the National Hispanic Family Against Drug Abuse (NHFADA). Our organization is the only Hispanic national group whose sole focus is to mobilize and assist Hispanic families and communities to combat and prevent drug and alcohol abuse, especially among young adults, teenagers, and children. Our affiliates include local community-based programs, volunteer groups, and other national organizations.

On behalf of our Board of Directors and our local and national affiliates, we appreciate this opportunity to submit our views on the important topic of federal funding and policy issues regarding anti-substance abuse programs, in particular as they relate to the critical needs and priorities of Hispanic communities.

Experience Under The War On Substance Abuse

Our Hispanic communities have responded overwhelmingly to the war on substance abuse approved by the Congress under the Omnibus Anti-Drug Acts of 1986 and 1988. For generations of Hispanics in this country, unchecked dependency on alcohol and illicit drugs has been a severe drain on our family and social fabric. Long overlooked or sidelined by officials outside of and also within our communities, this pervasive problem has been thrust into national and local awareness at last, thanks largely to the omnibus legislation and the infusion of new funds to implement it.

Along with that sharp upswing in awareness, great expectations for change have been ignited in our communities. So too has the sense of urgency, not only to act now to reverse the historical neglect and lack of responsiveness, but also to protect our future. We are keenly aware of the growing risks that substance abuse poses to our teenagers and young children. As you know, Hispanics are the most youthful population in this country, and we will account for 25% of the U.S. population growth over the next 20 years alone.

Adding to the urgency is the threat of AIDS and HIV infection, a threat which though evident years ago is only now commanding widespread attention and action. Hispanics comprise about 7% of the U.S. population, but comprise 15% of adult AIDS cases and 23% of pediatric cases. Increasingly, intravenous drug abuse is becoming the HIV transmission route to heterosexuals within all communities, including Hispanics. The Centers for Disease Control noted last month that slightly more than 55% of AIDS cases among Hispanics were IV drug-associated.

But while the positive response by Hispanic communities to the war on substance abuse has been great and continues to grow, it further illuminates major funding and policy issues that require your consideration and action to assure that we have the resources necessary to tackle the complex, interactive problems of substance abuse in a comprehensive, sustained manner.

The overall situation our communities face is this: treatment and prevention resources have been too scarce or scattered to make a sizeable impact; data and research on Hispanic substance abuse remain limited, often fragmentary; and the supply of Hispanic clinical and research personnel trained to serve our communities remains insufficient. True, this situation, which has developed over generations, will not be undone overnight. Yet we believe that important efforts have been to made to start to address these gaps, thanks to funds provided by the Congress under omnibus anti-drug legislation. These efforts need to be continued and strengthened, but new initiatives also need to be launched to insure progress over the long run.

With regard to support for continuing efforts and for new initiatives, we ask you to consider the following key issues:

• A greater proportion of Hispanics are in the age groups identified in the research as being at highest risk for alcohol and drug abuse -- namely, those between ages 12-17. For too many of our youth, these formative years are marred by school dropout or delinquency. Research indicates that among Hispanic youth, many do not believe that alcohol and other drugs are detrimental. Multiple drug use -- including inhalants, alcohol, marijuana, and cocaine -- is common. Further, given the tendency of young Hispanic males to drink more heavily than their non-Hispanic counterparts, alcohol is a leading cause of death among our youth.

• Because of the high birth rate among Hispanic teens, substance abuse is a special concern due to the well-documented the risks it poses to the health of these young mothers and their infants. In recent years, the drinking rates reported among young Hispanic women have increased alarmingly, and our affiliates report signs of an accompanying increase in the incidence of fetal alcohol syndrome, fetal alcohol effects, and addicted mothers.

• The incidence of drug-associated AIDS among Hispanic women and infants continues to grow. CDC researchers reported last year that the highest risk rates for AIDS among Hispanics were linked with intravenous drug abuse; that the risk of AIDS was 3.6 times as great for Hispanic women as it was for white women; and that the risk of HIV infection was 6.6 times as great for Hispanic children as it was for white children. In fact, the differences between Hispanics and whites were so great that the authors were moved to recommend that "Hispanic communities should be targeted for special efforts to treat intravenous drug abuse and to counsel IV drug abusers on the risk of HIV infection" (Richard M. Selik, Kenneth G. Castro, and Marguerite Pappaioanou, "Racial/Ethnic Differences in the Risk of AIDS in the United States," *American Journal of Public Health* 78, No. 12, December 1988: 1539-41).

• Hispanics continue to be over-represented among the victims of substance abuse. Young Hispanic males between ages 18-29 still have a higher drinking rate and drink more heavily than blacks or whites, and Hispanics continue to drink themselves to death at a rate that is twice that of whites. Nor has there been any evident decrease to date in the rate at which Hispanics present primary problems with heroin, cocaine, and other drugs, nor are Hispanics more likely today to be in treatment for a drug-related problem.

Recommendations

While we are in favor of the Administration's proposed continuation of the initiatives of ADAMHA in the war against substance abuse and of CDC's efforts against AIDS and HIV infection, we believe that more needs to be done to assist Hispanic communities. This can be achieved through a combination of funding increases in selected areas together with specific report language to guide initiatives in other areas. These are as follows:

1. We recommend increased accountability in the use of federal block grants to states for substance abuse treatment and prevention. According to reports from many of our affiliates and other local Hispanic leaders, few of these funds appear to be reaching and benefiting Hispanic communities despite their pressing need. These reports are underscored by my own experience when, in preparation for this testimony, I contacted the responsible agencies in a sampling of four states with large clusters of Hispanics. I raised specific questions concerning the number of Hispanic and other applications for funds, the the breakout of those which were funded, the amounts awarded and for what purposes, and the types of technical assistance offered to help Hispanic applicants be more competitive. Regrettably, one state did not answer, while the others were not able to be much more informative: one state would give no breakdown, one said only that it funded no new applicants, and one said it could provide only a "good informed guess."

Considering that more than $500 million of federal block grant funds are available to states for substance abuse activities, we believe that increased data collection and monitoring are urgently required to make sure this money is distributed to communities most at risk and most in need and that the states establish a "level playing field" for Hispanic groups in relation to other competitors.

For the purposes of such increased data collection and monitoring of Hispanic participation in block grant programs, we recommend the adoption of report language directing ADAMHA to obligate in the coming fiscal year $2 million of funds it is authorized to set aside for data collection, services research, and technical assistance under provisions of the Anti-Drug Act.

2. For the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism each, we recommend an increase of $10 million above the Administration's request to enable each Institute to develop and implement a targeted extramural research initiative that will examine the causes and key factors contributing to higher rates of substance abuse among Hispanics, study at-risk factors posing the greatest danger to our youth, and develop prevention

and treatment strategies based on the findings. Such an initiative should involve Hispanic investigators in multiple urban and rural sites throughout the country with major Hispanic population concentrations, and should examine problems with a variety of drugs such as inhalants, PCP, marijuana, cocaine, etc.

3. With NIDA and NIAAA principally focused now on biomedical research and with the bulk of treatment and prevention funds going to states under block grants, the demands for assistance from local groups throughout the country and from national organizations continue to be directed toward the Office for Substance Abuse Prevention. While OSAP has attempted to be responsive to Hispanic needs, these needs are much greater than the agency's current ability to fund. Substance abuse has long had a disproportionate impact on our communities, and it is only under the omnibus anti-drug legislation that we have begun to have access to financial and technical resources to counter the problem, though not enough to meet the challenge.

For this reason, we recommend a funding increase of $15 million above the Administration's request for OSAP, with one-third of the increase targeted toward strengthening and expanding capacity building programs and training among Hispanic local and national organizations engaged in or seeking to become involved in anti-substance abuse activities.

4. We recommend an additional increase of $2 million over the Administration's request for NIDA and NIAAA each for the purpose of much-needed training of Hispanic researchers in prevention and treatment.

5. We support the Administration's request for new positions within ADAMHA, and urge that you encourage the agency to use this opportunity to increase its hiring and promotion of Hispanics to important program management, budget, and policymaking positions. Such personnel are critically important in designing and implementing programs attuned to the needs and priorities of our communities.

6. Under funds provided last year to target minority communities, the Centers for Disease Control has been able to support an array of community-based organizations and to make funds available to states to help create a much greater awareness in these communities regarding AIDS and HIV infection. We urge that an additional $5 million be provided to CDC to intensify and expand this effort, given the fact that the incidence of AIDS is running as much as three times higher in minority communities than among non-minorities.

STATEMENT OF HENRI BEGLEITER, M.D., RESEARCH SOCIETY ON ALCOHOLISM

The Research Society on Alcoholism, comprising the basic and clinical scientists of the United States working in the field of alcoholism and alcohol abuse research, propose for your serious consideration an alternative to the President's budget for FY 1990 appropriations for the National Institute on Alcohol Abuse and Alcoholism.

As you know, alcoholism and alcohol abuse constitute major public health problems in America and impose a substantial public safety burden. These problems cost the nation's economy more than $116 billion annually, and yet the research needed to alleviate the economic and human costs amounts to approximately one-tenth of one percent of these costs.

Research on alcoholism and alcohol abuse has developed to the point that we as a nation can make significant strides in determining the causes of, and in preventing and treating, this serious disease. We have the tools to identify the gene or genes and biological and other markers which determine susceptibility to alcoholism and alcohol abuse. With proper research support we may prevent and better treat these problems and reduce the morbidity and mortality associated with them.

The Research Society on Alcoholism believes that several areas of research have the potential to be particularly fruitful, including the application of high technology imaging instruments to the actions of alcohol on the brain; the identification of genetic markers for determining susceptibility to alcoholism and alcohol abuse; and treatment modalities such as seratonin metabolism blockers and other new pharmacological agents which may alter alcohol consumption.

In order to take advantage of current research knowledge and build upon it, the Research Society on Alcoholism urges the Committee to provide a total of $172.8 million for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) for FY 1990, for all of its research programs as well as for the homeless demonstrations requested by the President. At this level of funding, NIAAA would be able to support continuing research projects at current service levels, and could support an additional 34 project grants to address the following new lines of research:

The development of markers of alcohol consumption would be a major contribution to the alcoholism field. Such markers would provide physicians with a test to recognize, at an early stage, disease resulting from heavy alcohol use, and further provide the physician with a tool which overcomes the barrier of patient denial thereby permitting early referral to alcoholism treatment. Such an objective marker of alcohol consumption would also provide alcoholism treatment professionals with a tool to assess treatment compliance by monitoring actual, rather than self-reported, drinking behavior. There have been significant advances in the alcohol research field which now permit an augmented quest for objective markers. These advances include promising indications that three distinct biological parameters (carbohydrate deficient transferrin, acetaldehyde adducts of blood proteins, and fatty acid ethyl esters) are altered with alcohol consumption.

A brain neurotransmitter system which has only recently been the subject of alcohol investigation, may be critically important to phenomena of alcohol intoxication, tolerance, dependence, and the memory impairments induced by alcohol use. This system which involves the primary stimulatory neurotransmitter of the brain (glutamate) and the specific receptor (n-methyl d-aspartate, NMDA) has been shown to be affected by alcohol at the low level of alcohol consumption associated with non-abusive drinking. Enhanced investigation, through several additional research projects, of alcohol's actions on the glutamate/NMDA system is clearly required.

A significant research advance in the neurosciences has been the development of high-technological imaging instruments which permit the non-invasive study of anatomy, physiology, and biochemical function within the brains of patients and normal human subjects. These techniques include Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), and Magnetoencephalography (MEG). These advanced imaging techniques have yet to be vigorously applied to study the actions of alcohol on the brain. Additional research projects would permit such research applications including the exploration of the actions of alcohol in specific brain structures and sites, as well as study of the processes by which alcohol can elicit specific organic brain disease.

The new cooperative genetics research program initiated last year through funding recommended by this Committee, represents a major effort to identify genes which contribute to the development of alcoholism in at-risk individuals. The cooperative effort will focus on individuals drawn from families at higher risk for the development of the disease. As advances in science occur over the next few years, particularly in molecular biology, there will be a clear and urgent need to use the resource of this cooperative genetic family study to explore new issues which will further define the nature of the genetic factors contributing to alcoholism risk. With the passing of time it will become increasingly difficult to access individuals from these families for the purpose of deriving new tissue samples. This situation can be rectified by establishing a cell repository which would maintain immortalized cells derived from the family members, and which would in turn make this resource available to the entire scientific community.

In a similar manner, as our knowledge of alcohol abuse increases, important refinements in diagnosis will occur which will be important to apply to the research projects derived from this cooperative genetic study. Such diagnostic improvements, and the information be derived from them must be stored, and made available to the entire scientific community. Funds are required for the cell repository and diagnostic improvement storage in FY 1990.

We also strongly support funding for 98 additional research trainees. There are currently critical shortages of alcohol investigators in a number of disciplinary areas which are vital for addressing the priority research issues facing the health community today. Most imperative is the need for investigators trained to approach a variety of alcoholism-related issues in clinical research from the disciplines of psychiatry, clinical and neuropsychology, neurology, internal medicine, gastroenterology, cardiology, perinatal medicine, pediatrics, and developmental psychology. These individuals are necessary to address pressing research issues related to the treatment of alcoholism, to the study of the organic brain disease and neuropathies derived from alcoholism, the study of alcoholic liver disease, alcoholic pancreatic disease, alcohol-derived diseases of the heart and circulatory system, clinical study of fetal alcohol syndrome and other alcohol-related birth defects, and the study of the impact of alcohol on the childhood and adolescent development processes.

A critical need also exists to train scientists for prevention research activities. Beyond the clinical and prevention research requirements is the need to train basic scientists who are addressing the increasing number of questions emerging from the current excitement and interest in many alcohol-related issues. These scientists would approach research questions which range from the interaction of alcohol with specific neuro-transmitter systems to the actions of alcohol in altering cell member function, to the study of the effects on peer interactions and family functioning. Because alcohol research is not in and of itself a unique discipline, but rather requires scientists from many diverse disciplines, the research training afforded through the NRSA program of NIAAA provides the specialized training essential to enter into active research in this area.

There is a great need to combine the research efforts of behavioral scientists and basic biomedical investigators in a team approach. It is now clear to the research scientists in the field that alcoholism and alcohol abuse are not entirely behavioral and environmental, or entirely biological. If we are to fully and appropriately address the disease and conditions of alcoholism and alcohol abuse, we must investigate the underlying etiologies through multidisciplinary approaches.

Attached to this statement is a table which provides in detail the recommendations of the Research Society on Alcoholism for FY 1990, and which compares the recommendations with the President's budget and funds appropriated for FY 1989. We will be pleased to serve as a resource to this Committee, and to answer any questions it may have regarding funding for the National Institute on Alcohol Abuse and Alcoholism.

The Research Society on Alcoholism appreciates the past support of this Committee for NIAAA research and urges it to consider fully and carefully our recommendations for FY 1990.

STATEMENT OF PHILIP OLIVER-DIAZ, DIRECTOR, CHILDREN AT RISK PARENT SUPPORT PROJECT

GOOD AFTERNOON, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO ADDRESS THE PRESIDENT'S FISCAL YEAR 1990 BUDGET FOR FEDERAL ALCOHOL AND OTHER DRUG ABUSE PROGRAMS.

MY NAME IS PHILIP OLIVER-DIAZ. I AM A FORMER MEMBER OF THE ALCOHOL, DRUG AND MENTAL HEALTH ADMINISTRATION ADVISORY BOARD AND A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION OF NATIVE AMERICAN CHILDREN OF ALCOHOLICS. I AM ALSO THE CO-CHAIRPERSON OF THE NATIONAL NETWORK ON HIGH RISK YOUTH AND FAMILIES. THE NETWORK IS A COALITION OF GRASSROOTS DRUG PREVENTION PROGRAMS, MINORITY PROGRAMS, AND THE FAMILY AND PARENTS MOVEMENT, SUCH AS FAMILIES IN ACTION AND THE NATIONAL FEDERATION OF PARENTS FOR A DRUG FREE YOUTH. THE PURPOSE OF THE NETWORK IS TO (1) IMPACT POSITIVELY ON THE OMNIBUS DRUG BILL AS IT RELATES TO HIGH RISK YOUTH (2) CREATE A NATIONAL CONSENSUS ON THE NEED FOR SPECIAL RESOURCES FOR HIGH RISK YOUTH AND (3) DELIVER INFORMATION ON RESOURCES FOR HIGH RISK YOUTH TO PROGRAMS THROUGHOUT THE COUNTY.

A MAGIC BULLET WILL NOT WIN THE WAR ON DRUGS. WE NEED TO FUND A SOCIAL MOVEMENT TO WIN THE WAR ON DRUGS

THE WAR ON DRUGS IS BEING FOUGHT NEIGHBORHOOD BY NEIGHBORHOOD, BLOCK BY BLOCK BUT LITTLE OF THE DRUG OMNIBUS MONEY IS REACHING US. THE PARENTS MOVEMENT HAS RECEIVED VERY LITTLE MONEY AT ALL. GRASSROOTS PROGRAMS HAVE NOT, TO A LARGE DEGREE, BEEN ABLE TO ACCESS THE FEDERAL DOLLARS AVAILABLE. THE ADAMHA INSTITUTES ARE ALL DIRECTED AT FUNDING THE MEDICAL AND UNIVERSITY ESTABLISHMENT. JUST AS THE MILITARY INDUSTRIAL COMPLEX CONTROLS THE DEFENSE MONEY THE UNIVERSITY MEDICAL COMPLEX CONTROLS ALCOHOL, DRUG AND MENTAL HEALTH DOLLARS.

TO SPEND MONEY WHICH COULD BE USED FOR PREVENTION AND TREATMENT PROGRAMS TO FIND A BLOCKING AGENT FOR COCAINE IS A WASTE OF TIME AND EFFORT. WE ARE NOT FIGHTING ONE DRUG WE ARE FIGHTING A LOSS OF WILL ON THE PART OF OUR PEOPLE. MOTHER TERESA HAS SAID THERE ARE ONLY TWO REALLY POOR COUNTRIES IN THE WORLD, INDIA AND THE UNITED STATES. INDIA IS THE POOREST COUNTRY MATERIALLY BUT THE UNITED STATES IS THE POOREST COUNTRY SPIRITUALLY.

WE NEED TO FUND THE SOCIAL MOVEMENT THAT IS NOW AND HAS BEEN FIGHTING THE WAR ON DRUGS IN THE HOUSING PROJECTS, ON THE STREETS AND IN THE SCHOOLS. THE ONLY FEDERAL OFFICE THAT HAS COME CLOSE TO HELPING THOSE OF US IN THE TRENCHES WHO ARE NOT TIED TO UNIVERSITIES AND MEDICAL SYSTEMS IS OSAP, THE OFFICE OF SUBSTANCE ABUSE PREVENTION. IN 1988 TWENTY THREE MILLION DOLLARS WAS ALLOCATED FOR NEW HIGH RISK YOUTH GRANTS. IN 1989 ONLY SEVEN MILLION HAS BEEN SET ASIDE FOR NEW HIGH RISK YOUTH GRANTS. THE DEMONSTRATION GRANTS PORTION OF OSAP NEEDS TO BE ENHANCED.

THERE IS ONLY SEVEN MILLION DOLLARS AVAILABLE FOR NEW STARTS IN SEPTEMBER OF 1989 THIS IS CRIMINAL, ONLY THIRTY NEW STARTS WILL BE FUNDED IN SEPTEMBER 1989!

THE PEOPLE IN THE STREETS IN COMMUNITY BASED SETTING WORKING OUT OF CHURCHES, WORKING OUT OF STOREFRONTS DON'T GET THE DOLLARS TO RUN PROGRAMS! THEY CAN'T AFFORD TO COME TO TESTIFY THEY DON'T KNOW CONGRESSIONAL OR SENATORIAL AIDES ON A FIRST NAME BASIS, BUT THEY ARE THE BACKBONE OF AMERICA AND AMERICA'S WAR ON DRUGS.

WE NEED TO INITIATE THE FORMATION OF PUBLIC/PRIVATE SECTOR PARTNERSHIPS IN INDIVIDUAL COMMUNITIES TO DEVELOP PROGRAMS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT

IN RESPONDING TO REQUESTS FROM THROUGHOUT THE COUNTRY FOR ASSISTANCE IN DEVELOPING OR STRENGTHENING PREVENTION SERVICES OSAP HAS BECOME INCREASINGLY AWARE OF THE NECESSITY OF ADAPTING A COMPREHENSIVE, MULTI-DISCIPLINARY APPROACH, PARTICULARLY IN WORKING WITH LARGER COMMUNITIES. IN RECOGNITION OF THE FACT THAT SUBSTANCE ABUSE PREVENTION IS A LONG RANGE, COMPREHENSIVE PROCESS, THE BUSH BUDGET HAS REQUESTED $35 MILLION FOR A NEW PROGRAM OF COMMUNITY PARTNERSHIP GRANTS FOR DRUG ABUSE PREVENTION. THE PROPOSED INITIATIVE WOULD DEMONSTRATE THE EFFECTIVENESS OF THE COMMUNITY COALITIONS OF ORGANIZATIONS REPRESENTING PARENTS, SCHOOLS, ACADEMIA, BUSINESSES AND YOUTH AND OTHER AT-RISK INDIVIDUALS IN THE PLANNING AND IMPLEMENTATION OF COMPREHENSIVE PREVENTION PROGRAMS. THE COMMUNITIES

THEMSELVES WOULD DEVELOP PROGRAMS DESIGNED TO BE SELF SUSTAINING AND NOT DEPENDENT ON PERMANENT FEDERAL SUPPORT. I IMPLORE YOU TO ADOPT THE BUSH PROPOSAL FOR THE COMMUNITY PARTNERSHIP PROGRAM. AUTHORITY FOR THIS PROGRAM IS PROVIDED UNDER SECTION 508 (B) (10).

WE NEED TO STAFF THE FEDERAL AGENCIES THAT ARE FIGHTING THE WAR WITH ENOUGH GOOD PEOPLE

OSAP NEEDS MORE FTE'S. THEY ARE GROSSLY UNDERSTAFFED. ALL TOO OFTEN WHEN CONGRESS AND THE SENATE GIVE ALLOCATIONS THEY DON'T MANDATE THAT ADEQUATE STAFF ARE HIRED AND BECAUSE OF ADMINISTRATION BUDGET REQUIREMENTS NEEDED PERSONNEL ARE NOT ADDED ON TO ENABLE AGENCIES TO FULFILL THEIR MISSION. WE CAN NOT HAVE A WAR ON DRUGS WITHOUT ADEQUATE PERSON POWER.

IF YOU ASK FOR AN ESTIMATE OF WHAT IS NEEDED YOU WOULD GET IT AND YOU COULD MANDATE APPROPRIATE STAFFING.

WE NEED TO ALLOW NOT-FOR-PROFITS WHO HAVE BEEN FIGHTING THE WAR ON DRUGS FOR YEARS TO RECEIVE CONTRACTS.

PRESENTLY BECAUSE OF AN ADAMHA POLICY STEMMING FROM THE SMALL BUSINESS ADMINISTRATION ONLY FOR PROFITS MAY BID ON CONTRACTS FOR GIVING TECHNICAL ASSISTANCE ETC. THIS MEANS THAT THE NOT-FOR-PROFITS LIKE FAMILIES IN ACTION AND THE MICHIGAN INSTITUTE ON BLACK CHEMICAL ADDICTION (MIBCA) HAVE NOT BEEN ABLE TO RECEIVE CONTRACTS EVEN THOUGH THEY HAVE BEEN THE LEADERS IN THEIR AREAS ON THE WAR ON DRUGS FOR MANY MANY YEARS. NEW BELTWAY BANDITS HAVE SPRUNG UP TO RIP OFF THE DOLLARS WHEN THOSE WHO HAVE FOUGHT SO LONG AND KNOW SO MUCH ARE CLOSED OUT. THIS MUST BE CHANGED. I ASK YOU TO LOOK INTO THIS SITUATION, ASK THE SECRETARY OF HHS TO EXPLAIN THE SITUATION AND IN THE NEXT OMNIBUS BILL RECTIFY THIS INCREDIBLE SITUATION.

SOME AGENCY NEEDS TO TAKE THE LEAD NATIONALLY FOR THE TREATMENT OF YOUNG DRUG ADDICTS AS WELL AS PREVENTION AND THAT AGENCY IS OSAP

ON THE NATIONAL LEVEL NO ONE AGENCY IS LEADING THE FIGHT TO TREAT OUR NATIONS ADDICTS, ESPECIALLY OUR YOUNG ADDICTS. WHILE OSAP HAS BEEN GIVEN THE LEAD TO DEVELOP A NATIONAL DRUG PREVENTION MOVEMENT, TREATMENT STILL LANGUISHES WITH NO NATIONAL DIRECTION. CONGRESS AND THE SENATE CAN REMEDY THIS BY EXPANDING OSAP'S MANDATE TO INCLUDE TREATMENT AND TO DIRECT THE SECRETARY OF HHS TO WITH THE ASSISTANCE OF THE DIRECTOR OF OSAP, CREATE A NATIONAL PLAN FOR THE TREATMENT OF AMERICA'S DRUG ADDICTED YOUNG PEOPLE.

WE NEED TO OPEN OUR HEARTS TO THE REAL ISSUES

MUCH HAS BEEN SAID ABOUT THE NEED FOR EVALUATION AND THERE HAS BEEN CRITICISM FROM THE MEDICAL COMMUNITY ABOUT THE LACK OF HIGH LEVEL RESEARCH IN THE AREA OF DRUG PREVENTION PROGRAMMING. I ASK YOU HOW DO YOU EVALUATE THE MOVEMENT OF THE HUMAN HEART. HOW DO YOU QUANTIFY A CHILD'S TRUST, A PARENT'S TEARS AND A COMMUNITIES WILL TO WIN THE WAR ON DRUGS. THOSE OF US IN THE TRENCHES SEE THE RECOVERY IN THE EYES OF THE CHILDREN.

FOR ME PREVENTION LIES IN THE HEARTS OF THE CHILDREN. LET ME TELL YOU A BRIEF STORY ABOUT ONE GROUP OF TEENAGE

CHILDREN OF ALCOHOLICS. I RAN A PROGRAM CALLED PROJECT RAINBOW IT WAS ONE OF THE FIRST FOR CHILDREN OF ALCOHOLICS. IN OUR GROUPS WE HAD CHILDREN OF MANY COLORS. DURING ONE PARTICULAR GROUP ONE OF THE WHITE CHILDREN WHO HAD COME TO US AFTER GETTING INTO A FIGHT WITH A POLICE OFFICER, SAID HE HATED THE "NIGGER" THAT HIS MOTHER DATED. I REMEMBER THINKING THAT THERE WOULD BE A FIGHT BETWEEN THE BLACK AND WHITE TEENS, BUT AS I LOOKED AT THE BLACKS THEY TENSED UP BUT DID NOT MOVE. THE NEXT CHILD SAID HE HATED THE "SPIC" THAT HIS MOTHER DATED AND NOW THE HISPANIC CHILDREN TENSED AND I WAS REALLY WORRIED.

EVEN THOUGH MY HEAD SAID THAT THE ISSUE WAS RACISM MY HEART SAID SOMETHING ELSE AND I FOLLOWED MY HEART. FINALLY ANOTHER TEEN SAID ALL THEY DO IS DRINK AND GO OUT AND ALL THE KIDS STARTED TO ECHO THIS. FINALLY THE BIG WHITE KID THAT HAD STARTED ALL THIS SAID WITH TEARS IN HIS EYES, "THEY'RE SUPPOSED TO LOVE US AND THEY DON'T". THE GROUP WENT SILENT BECAUSE THIS KID HAD STATED THE PAIN FOR ALL THE KIDS. AND I WENT SILENT BECAUSE THERE WAS NOTHING MORE TO SAY. NEXT TO THIS KID WAS A CHUBBY LITTLE PUERTO RICAN GIRL SUDDENLY SHE LEANED OVER TO THE WHITE KID HUGGED HIM AND SAID I'M A "SPIC" AND I LOVE YOU. AT THAT POINT ALL THE KIDS CRIED AND I DID TO AND HELD ONE ANOTHER. WHAT I SAID TO THE KIDS AT THAT POINT WAS THAT THEIR PARENTS WERE EMPTY WELLS RIGHT NOW BUT THEY WERE FULL WELLS AND THAT THIS IS WHAT IT FEELS LIKE TO HAVE THEIR NEEDS MEET. I HAVE SEEN THOSE KIDS FROM OUR PREVENTION GROUP OVER THE YEARS AND MANY OF THEM HAVE DONE WELL. BUT TELL ME HOW DO YOU QUANTIFY THE MOVEMENT OF THE HUMAN HEART.

ALL TOO OFTEN CONGRESS IS SWAYED BY SOME M.D. OR Ph.D WHO HAS WARNED US OF ACTING WITH OUT "FACTS". I DON'T KNOW WHAT THEY MEAN BY THAT. I SIT ON MANY COMMITTEES. ONE OF THE COMMITTEES I SIT ON IS THE IRB FOR DRUG RESEARCH IN NEW YORK STATE. I HAVE WATCHED WHILE MILLIONS OF DOLLARS GET SPENT ON RESEARCHING THE OBVIOUS WHILE CHILDREN DIE DAILY IN THE CRACK WARS ON THE STREETS. THERE IS NO COMPARABILITY IN FUNDING BETWEEN THE SERVICE ORIENTED AND RESEARCH ORIENTED INSTITUTES ON THE NATIONAL LEVEL. THE RESEARCH SCIENTISTS DON'T KNOW WHAT'S HAPPENING IN THE STREETS WE THE GRASSROOTS WORKERS DO. MY FATHER DIED IN A BAR FIGHT WHEN I WAS A CHILD. MY UNCLE WAS A HEROINE ADDICT, MY BROTHER AND I ARE BOTH RECOVERING ADDICTS, MANY OF MY FRIENDS FROM MY DRUG DAYS ARE DEAD. WE KNOW THE PROBLEM AND WE KNOW SOME OF THE SOLUTIONS. BUT WE CAN'T WRITE FANCY PROPOSALS WITH EXTENSIVE LITERATURE SEARCHES LIKE THE UNIVERSITIES DO. WE CAN'T MAKE TRIP AFTER TRIP TO WASHINGTON TO TALK TO STAFF TO CONVINCE THEM OF THE RIGHTNESS OF OUR IDEAS.

WE ARE STILL IN THE STREETS LIKE THE INTEGRITY PROGRAM IN NEWARK THAT WAS PREVENTING DRUG ABUSE WITH HARD CORE KIDS UNTIL IT'S OSAP MONEY RAN OUT LAST YEAR, IN THE BUSH LIKE THE RURAL CAP PROGRAM IN ALASKA THAT HAS HELPED FIVE NATIVE TRIBES GET SOBER AND HAS ONE MORE YEAR BEFORE IT SHUTS DOWN, CARING FOR THE BABIES BORN TO ADDICTED MOTHERS LIKE HALE HOUSE IN NEW YORK AND OPERATION PAR IN FLORIDA. WE ARE STILL HERE INFORMING THE PUBLIC ABOUT THE REAL FACTS LIKE FAMILIES IN ACTION IN ATLANTA THAT PUBLISHES DRUG ABUSE UPDATE ON A SHOE STRING SO THAT PARENTS CAN HAVE USEFUL INFORMATION FOR THEIR CHILDREN AND HAS NOT BEEN ELIGIBLE TO RECEIVE A CONTRACT FROM THE FEDERAL GOVERNMENT TO DO THIS WORK BECAUSE IT IS A NOT-FOR-PROFIT!

WE ARE STILL HERE AS THE UNIVERSITIES AND THE BELTWAY BANDITS LINE UP TO DIVERT THE DOLLARS WE ARE STILL HERE WAITING FOR YOU TO FORCE THE FEDERAL GOVERNMENT TO GIVE US THE MEANS TO FIGHT A REAL WAR WE ARE STILL HERE AMERICA'S GUERRILLA ARMY WAITING FOR HELP.

THANK YOU FOR YOUR TIME AND ATTENTION.

STATEMENT OF WILLIAM L. DEWEY, PH.D., CHAIRMAN, THE COMMITTEE ON PROBLEMS OF DRUG DEPENDENCE

Mr. Chairman and members of the Subcommittee, my name is William L. Dewey, Ph.D. I am Associate Provost for Research and Graduate Affairs and Professor of Pharmacology at Virginia Commonwealth University in Richmond, Virginia.

I am speaking today as Chairman of the Committee on Problems of Drug Dependence, or CPDD. We appreciate this opportunity to present our views on drug abuse research.

CPDD, organized in 1929, is the longest-standing scholarly society in the United States aimed at addressing the problem of drug abuse in this country. Today CPDD is composed of a multidisciplinary panel sponsored by ten professional medical and scientific societies on which many of the most distinguished basic science and clinical researchers in the area of drug abuse serve. The Committee has three principal functions. First, we test all new therapeutic compounds being developed to treat diseases of the brain to determine their potential to produce drug dependence or abuse. Second, we hold the major scientific annual meeting in the U.S. in the field of drug abuse. Finally, we function as an information resource for national and international government agencies on issues relating to drug abuse and dependency.

I am here today to request that the Congress appropriate sufficient funds to promote the continuation and ensure the expansion of non-AIDS drug abuse research at the National Institute of Drug Abuse (NIDA). Drug abuse is a major problem confronting today's society. Today, there are an estimated 1.2 million chronic intravenous drug abusers. Over 22 million Americans have tried cocaine. 85% of high school seniors say it is easy to purchase marijuana; 54% say it is easy to buy cocaine. 30% of recently diagnosed AIDS patients are intravenous drug abusers. 70% of all AIDS babies are the children of intravenous drug abusers.

Basic research into the prevention and treatment of drug abuse and dependence is therefore among the most critical needs of our time. The societal costs of drug abuse continue to mount at an alarming rate and the problems have reached every neighborhood in America. The cost of treating addiction mounts steadily as well. It has been estimated that the health costs of caring for drug addicts now exceed $50 billion.

In view of the prevalence of drug abuse in this country and in light of President Bush's pledge to combat this critical problem, we must ensure that sufficient resources are appropriated for drug abuse research. In light of our limited resources, the decision is a difficult one; but one factor that must be considered is how much money is currently spent on drug abuse research compared to other programs. In the FY 1990 budget, research on drug abuse comprises one half of one percent of the total Federal research and development budget. In 1990 alone, more money will be spent on cancer research than has been spent on drug abuse research over the last seventeen years. Comparison of drug abuse budgets to defense or other budgets makes it clear that we do not have now nor never had a "war on drugs." If our society wants to make a long-term commitment to the prevention and treatment of drug abuse research, Congress must support additional funding of non-AIDS research.

The Administration's FY 1990 proposed budget calls for $180,677,000 for non-AIDS research and demonstration projects at the National Institute on Drug Abuse. This budget proposal represents an increase of approximately $9.9 million or 5.8% over the FY 1989 estimate. This proposal would allow NIDA to award 167 new and competing grants, 2 new research and development contracts and one new drug abuse research center.

CPDD strongly supports the Administration's proposal to increase the non-AIDS budget for NIDA for fiscal year 1990. CPDD, however, would like to submit an alternative budget proposal that would provide a larger increase in the non-AIDS budget. (See attachment.) The current level of services proposed for non-AIDS research and demonstration projects for FY 1990 is $185,418,000. The Administration's proposed budget does not meet the current level of proposed activities. Our alternative proposal would call for $206,719,000 and thereby provide the necessary and sustained funding to match the current level of proposed non-AIDS research activities and demonstration projects for FY 1990 and promote the support of future research activities.

In contrast to the Administration's proposal, which will support only 167 new and competing project grants (33 less than were supported in 1989), our recommendation would allow NIDA to award 240 new and competing project grants of significant merit, including projects designed to develop new treatments and identify factors affecting vulnerability to drug abuse. This funding represents 40 more grants than were supported in 1989. The President's request for FY 1990 will support one new drug abuse research center and one small grant. Our alternative budget proposal for the non-AIDS program will support two new drug abuse research centers and ten small grants. Our recommendation will also support ten new research career programs designed to attract clinicians to drug abuse research, in contrast to five new research career awards that would be provided under the President's budget. The Administration's budget proposal would support 92 research trainees (13 less than were supported in 1989) while our proposal would double the size of the training program from the 1988 level. Finally, our budget proposal would allow NIDA to support five new research and development contracts, in contrast to the two contracts that would be provided under the Administration's budget proposal.

Significant advances have been made in the field of drug abuse as a result of NIDA funded research. In the area of drug abuse prevention, NIDA supported research has resulted in a 50-75 percent short-term reduction in cigarette smoking among junior high school students. This research should be expanded to determine the long-term efficacy of these programs and the application of these principles to other drugs of abuse. Ongoing studies have demonstrated that increasing the confidence and self-esteem levels of the young helps them resist peer pressure to become drug abusers. Additional research funded by NIDA has also focused on the question of vulnerability by exploring whether certain persons are more predisposed biologically than others to substance abuse. Research has already begun on the brain wave pattern of certain parents and their children which indicates a potential genetic pre-disposition to substance abuse.

The research exemplified above will help us increase our understanding of the basic pharmacological and behavioral mechanisms of abused drug action and develop strategies for preventing drug abuse in the future. The prevention of drug abuse is a far better alternative than its treatment. Preventing drug abuse will also lessen the transmission of AIDS by intravenous drug abusers. We therefore urge the Committee to support our alternative budget proposal that will ensure that a fair portion of the funds allocated to non-AIDS research will be allotted to drug abuse prevention.

Significant progress has also been made in the area of treatment of drug abuse. Financial support from NIDA has enabled researchers to develop a new drug, naltrexone, the only pharmaceutical agent other than methadone that has been approved for the treatment of drug abuse. This drug is being used widely and is saving thousands of lives today. NIDA funded research has also been instrumental in the production of an antibody against PCP that may be useful in treating its toxic effects. Finally, new procedures have been developed to reveal drug induced neuropathology and to detect drugs in the urine.

One of the principal benefits of NIDA funded research is the positive effect it has had on other areas of research aimed at improving health. Due to the significant progress that has been made in drug abuse research, substantial progress has also been made in other scientific, biomedical and behavioral research areas. Indeed, work supported by NIDA contributes to our understanding of brain function and the treatment of many diseases of the brain.

Continued stable funding for drug abuse research is essential not only to support existing programs but also to ensure a stable base of new funds for which scientists can compete. Although the drug abuse research program has been greatly expanded over the past several years, there has not been stability and consistency in this growth. The expansion of drug abuse research in FY 87 was not upheld in FY 88. Funds available for new initiatives declined by nearly 45 percent. New funds for non-AIDS initiatives will decline by almost 30 percent from FY 89 to FY 90. This lack of consistency in the non-AIDS budget makes it difficult to conduct an orderly expansion of the drug abuse research program. In addition, it discourages young scientists from entering the field of drug abuse research due to a perceived lack of committment to the area.

Additional funding is essential to continue making significant advances in the field of drug abuse. Development of new pharmacotherapeutics to aid in the treatment of drug abuse is the number one research priority of the Institute. We endorse this initiative. Among the thousands of pharmaceuticals available today, only two, methadone and naltrexone, have been specifically developed to treat the problem of drug abuse. We need new drug treatments for chronic cocaine users. Three drug products show immediate promise of offering clinical utility in the area of drug abuse. Funds provided in the Anti-Drug Abuse Act of 1988 allowed NIDA to expand its drug development efforts and to create a focused program aimed at developing drugs for the treatment of addictive disorders. Additional funding, particularly for contracts, will be necessary in 1990 to maintain this initiative and allow the development of promising new drugs.

Additional funding is also necessary to expand research on the neural basis for genetic predisposition and vulnerability to drug abuse on the treatment of cocaine abuse and on the effects of maternal drug use on infant development. More qualified scientists are needed to expand the drug development program. The expansion of drug abuse research in the past several years has been made possible by the ability of NIDA to attract scientists from other areas. But the continued success of the program will require a major investment in training young scientists in special techniques necessary for drug abuse research. Shortages of trained scientists are already being encountered in certain areas. More chemists and pharmacologists are required to expand the drug development program and more clinicians are needed to conduct clinical trials of new drugs.

In conclusion, the problem of drug abuse pervades our society and has a tremendous impact on human and economic conditions. As a result of NIDA funded research, significant strides have been made in the areas of prevention and treatment of drug abuse. This progress must continue. Indeed, we salute the leadership of ADAMHA's Administrator, Dr. Frederick Goodwin, and NIDA's Director, Dr. Bob Schuster. We, therefore, strongly support the Administration's increased appropriation for non-AIDS research at NIDA. Still, we believe additional funding will be necessary to restore the research initiative begun in 1987 and provide the essential resources for the orderly and promising growth and expansion of drug abuse research. Accordingly, we urge the Committee to support our alternative budget proposal that will ensure that we reach this objective.

I thank you for this opportunity to appear before you and I am grateful for your outstanding leadership in the past in providing funding for research in this critical area. I would be pleased to answer any questions at this time.

STATEMENT OF HECTOR F. MYERS, PH.D., NATIONAL CONFERENCE ON THE TRAINING OF MINORITY PSYCHOLOGISTS

My colleagues and I would like to share our deep concern for the continued and increased funding of the National Institute of Mental Health's (NIMH) programs for clinical training, especially those that are targetted to increase the number of trained racial/ethnic mental health professionals. There is ample demographic evidence that ethnic/racial minorities will constitute a large and diverse segment (25% - 30%) of the population in the United States by the turn of the century. Recent evidence from the NIMH-sponsored Epidemiologic Catchment Area study (ECA), as well as reports from CDC, NIDA and NIAAA indicate that racial/ethnic minorities continue to be at significant disadvantage in obtaining appropriate mental health services due to continued barriers to services. One of the most critical obstacles to appropriate mental health services continues to be the limited number of trained ethnic/racial minority mental health professionals. A related obstacle is the limited expertise non-minority mental health professionals have that equips them to work effectively with the variety of ethic/racial clients that are likely to seek such services from the public mental health sector.

The National Institutes of Mental Health (NIMH) has continued to provide funding for clinical training programs in Psychiatry, Psychology, Social Welfare and Nursing that prioritize the training of minority mental health professionals. This funding has also fostered the development and active incorporation of more culturally relevant content into the core curricula of clinical training programs to impact the cultural competence of all mental health professionals. Unfortunately, recent budgetary constraints and institute priorities have resulted in a reduction in the number of such programs funded, thus threatening to reverse some of the hard fought successes in minority manpower development. It is very clear from the available evidence that the mental health needs of ethnic minorities can be expected to increase dramatically in the next decade as large numbers of ethnic immigrants try to acculturate to America (e.g. Southeast Asians, Latin Americans, etc.) , and as large subsets of native minority groups continue a downward socio-economic shift (e.g Afro-Americans, American Indians, Mexican Americans, etc). It is imperative that we increase the level of funding for the training of more mental health professionals from these groups, especially clinical psychologists, in order to meet the expected increases in demands for services.

Towards this end, a group of more than sixty of the top clinical and counseling psychologists with interest and expertise in the ethnic minority mental health training in the country convened at UCLA on June 19-21, 1988 at a national conference sponsored by NIMH. The goal of the conference was to make a series of recommendations to NIMH to guide its decisions regarding the training of clinical psychologists to improve the quality of treatment and rehabilitation services provided to ethnic minority clients. This stellar group of psychologists were unanimous in making the following recommendations to NIMH:

1. That generic clinical training grants for ethnic minorities be restored in order to insure continuity of current efforts to build the pool of trained ethnic minority psychologists.
2. Since specialized training is needed to conduct effective assessment and treatment of mental health problems in ethnic minority clients, "ethnic minority populations" should be defined as an additional population priority in the minority students, faculty scholar, and in all future NIMH training program announcements.
3. That NIMH define minority faculty development as a top priority for support in order to insure adequate number of ethnic faculty to participate in these training programs.
4. That NIMH support ethnic minority faculty at different stages on their professionals careers by extending the Faculty

Scholar to include more senior minority clinicians, administrators, and faculty who are close to tenure and promotion reviews.

5. That NIMH increase the current base rate levels of support for both predoctoral and postdoctoral fellowships, and that the predoctoral fellowships be adjusted commensurate with the level of student training and experience.
6. That the number of years awarded in all training grants be increased from 3 years to 5 years to insure greater program continuity.
7. That in the final analysis, it is imperative that NIMH increases the overall pool of funds allocated to support minority mental health training at all levels if we are to have the manpower needed to meet the mental health service needs of these communities.

As the organizer and convener of the UCLA conference and official representative of the participants, I would like to share these recommendations with you and strongly urge you to support the continuation and enhancement of the funding to the National Institute of Mental Health that is specifically earmarked for the training of more ethnic minority psychologists and other mental health professionals.

On behalf of my colleagues, I would like to express my appreciation to the committee for allowing us this opportunity to contribute to your deliberations on the NIMH budget for clinical training.

STATEMENT OF THE AD HOC GROUP FOR MEDICAL RESEARCH FUNDING

Every year since 1982, the Ad Hoc Group for Medical Research Funding -- a diverse coalition of voluntary health agencies, professional and scientific societies, and research institutions -- has developed budget proposals for the National Institutes of Health (NIH) and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) and forwarded these to the Congress as an alternative

to the administration's budget requests. A list of the 129 organizations that have endorsed the Group's FY 1990 proposal to date is attached.

This year's proposal is made with a full awareness of the fiscal crisis that confronts the nation. One of the challenges facing America as it enters its third century is the reconciliation of the federal budget deficit, which threatens to deplete our nation's resources and vitality, with an equally pernicious threat to our national strength: the economic and emotional loss caused by disease and disability. It is an unfortunate truth that the costs of human disease and disability, in suffering, in loss of human potential and in the negative impact on the nation's economy, are not lessened by the magnitude of the budget deficit. The promise of medical research for reducing these human and economic costs, as well as for contributing positive benefits to the nation's international competitive position, makes the support of NIH and ADAMHA a high priority investment in the nation's future, even in times of fiscal austerity.

NIH:

FY 1989 Comparable*	FY 1990 Current Services*	FY 1990 Ad Hoc Group Recommendation*
$7.101 billion	$7.958 billion	$8.416 billion

* Does not include funds for intramural buildings and facilities or extramural construction.

An appropriation equal to at least the current services estimate of nearly $8 billion is required to maintain NIH programs at their current operating level. Part of this increase can be related to the rising cost of research because of the demand for increasingly sophisticated scientific methods and equipment and for more highly trained scientific personnel.

An even more significant component of this increase stems from the recent NIH practice to "downward negotiate" the size of research project grants. These administrative reductions in grants from advisory committee recommended levels -- averaging 10 percent in FYs 1988 and 1989 -- reflect a sound NIH policy objective: to maintain a semblance of stability in the number of competing research project grants. However, cuts of this magnitude are a false economy; they simply result in less research. Thus, the current services estimate reflects, in large measure, the difference between last year's arbitrarily lowered award level and the level of expenditure recommended for this year by the national advisory apparatus. Nearly two-thirds of the $946 million difference between the FY 1989 budget and the current services estimate for the FY 1990 budget is attributable to the restoration of these reductions.

In addition, NIH has extended the period of commitment of funds to research project grants. Over 50 percent of the research project grants awarded in 1988 were for 5 years, compared to approximately 20 percent in the mid 1980s. These longer awards enable scientists to devote more time to the conduct of research rather than spending time preparing more frequent applications. Lengthening the award period, however, increases the amount of funding needed to support noncompeting research project grants.

Most of the 7.2 percent increase in funding for NIH in FY 1989 will go to support noncompeting research awards and for increases in AIDS programs. As a result, there is a significant decrease in the funds available for competing research projects in FY 1989. At the same time, both noncompeting and competing research project grants will again face average cuts of 10 percent from recommended levels.

The Ad Hoc Group recommendation recognizes the need to restore funding of research project grants to the recommended level and to maintain some measure of growth in the system to provide support for new people and new ideas. To achieve these objectives, the Group's recommendation would provide adequate money to fully fund one out of three approved competing research project grant applications in FY 1990.

A second area of concern is research training. The Group's recommendation would provide support for approximately 11,800 National Research Service Award trainees -- an increase of 5 percent over FY 1988 -- with adequate funds to cover the modest increases in pre- and post-doctoral stipends allowed last year by NIH. The proposal also would support approximately 250 additional research career awards, bring the total to nearly 1,800.

The Group's proposal would be sufficient to provide modest additional funding for other areas of current support, including General Clinical Research Centers, cooperative clinical research, Biomedical Research Support Grants, Minority Biomedical Research Support, the NIH intramural program, and medical information management and transfer.

ADAMHA:

FY 1989 Comparable	FY 1990 Current Services	FY 1990 Ad Hoc Group Recommendation
$706 million	$793 million	$933 million

The Group's FY 1990 proposal recognizes the need for adequate funding to expand all areas of ADAMHA's research and research training mission. Particular emphasis would be placed on the National Plan for Research on Schizophrenia and the "Decade of the Brain" initiative in the neurosciences, as well as expanded research on the neurological and genetic aspects of addictive disorders, the relationship between drug abuse and HIV infection, and mental disorders in children and the elderly.

This proposal would support 920 competing research project grants, allowing ADAMHA to fund one out of three approved applications. The number of research centers would be increased from 73 to 87.

Research training would increase from 1,256 trainees in FY 1989 to 2,388 in FY 1990. It is essential that a significantly increased investment be made in research training in the areas of mental health and the addictive disorders. Particular emphasis is placed on the support of new clinical investigators. Absent expanded investment in trainees, the current shortage of physician scientists for research in areas such as aging, alcoholism, schizophrenia, affective disorders, disorders of children and adolescents, drug abuse and other major disorders will grow more serious at the very moment the scientific potential in these fields is expanding.

The Ad Hoc Group is gratified that Congress provided funding in FY 1989 to initiate a grant program for small instruments at ADAMHA. For FY 1990, the Group's proposal includes funds to increase the number of these awards from 40 to 110.

CONSTRUCTION: With some exceptions, facilities for extramural research have been steadily deteriorating and should be upgraded as soon as possible. In FYs 1988 and 1989, Congress appropriated a total of $28.9 million to repair, renovate, modernize and expand existing extramural facilities and purchase equipment for AIDS research. For FY 1990, the Ad Hoc Group recommends $50 million to continue the renovation of facilities for AIDS and animal research. An appropriation of an additional $250 million is recommended to repair, renovate and replace existing extramural research facilities through a new combined NIH-ADAMHA construction program, yet to be authorized. The total cost of repairing and/or replacing the research facilities for the conduct of federally-supported medical research is far beyond what can reasonably be expected in the near future; however, each year the Congress fails to address this problem continues the erosion of the nation's medical research capacity and increases the ultimate cost of its restoration.

Finally, the Group recommends $127 million for the continuation of two construction projects on the NIH campus in Bethesda, MD: Building 49, the child health - neurosciences building, which would also house part of the NIMH intramural program; and a consolidated office building, which would relieve the pressing need for additional space to administer the NIH extramural research program.

The Ad Hoc Group For Medical Research Funding

ORGANIZATIONS ENDORSING FY 1990 RECOMMENDATIONS

May 11, 1989

Albert and Mary Lasker Foundation
Alliance for Aging Research
Alzheimer's Disease and Related Disorders Association
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology -- Head and Neck Surgery, Inc.
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association for Cancer Research
American Association for Dental Research
American Association for Thoracic Surgery
American Association of Anatomists
American Association of Cancer Institutes
American Association of Chairmen of Departments of Psychiatry

American Association of Colleges of Nursing
American Association of Colleges of Pharmacy
American Association of Directors of Psychiatric Residency Training
American Association of Immunologists
American Association of Pathologists, Inc.
American Association of University Professors
American Cancer Society
American College of Cardiology
American College of Neuropsychopharmacology
American College of Nuclear Physicians
American College of Obstetricians and Gynecologists
American College of Psychiatrists
American College of Rheumatology
American Council on Education
American Dental Hygienists Association
American Diabetes Association
American Federation for Clinical Research
American Foundation for AIDS Research
American Gastroenterological Association
American Heart Association
American Institute of Ultrasound in Medicine
American Lung Association
American Mental Health Fund
American Narcolepsy Association
American Neurological Association
American Otological Society, Inc.
American Pediatric Society
American Physiological Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Red Cross
American Society for Biochemistry and Molecular Biology
American Society for Cell Biology
American Society for Clinical Nutrition
American Society for Microbiology
American Society for Parenteral and Enteral Nutrition
American Society for Pharmacology and Experimental Therapeutics
American Society for Virology
American Society of Clinical Oncology
American Society of Hematology
American Society of Human Genetics
American Speech, Language and Hearing Association
American Surgical Association
American Veterinary Medical Association
Ankylosing Spondylosis Association
Arthritis Foundation
Association for Academic Surgery
Association for the Behavioral Sciences and Medical Education
Association of Academic Health Centers
Association of Academic Physiatrists
Association of American Medical Colleges
Association of American Universities
Association of American Veterinary Medical Colleges
Association of Anatomy Chairmen
Association of Anesthesia Program Directors
Association of Biotechnology Companies
Association of Chairmen of Departments of Physiology
Association of Departments of Family Medicine
Association of Independent Research Institutes
Association of Medical School Departments of Biochemistry
Association of Medical School Microbiology Chairmen
Association of Medical School Pediatric Department Chairmen
Association of Minority Health Professions Schools
Association of Neuroscience Departments and Programs
Association of Orthopaedic Chairmen
Association of Pathology Chairmen
Association of Professional Sleep Societies

Association of Professors of Gynecology and Obstetrics
Association of Professors of Medicine
Association of Schools of Public Health
Association of Teachers of Preventive Medicine
Association of University Anesthetists
Association of University Professors of Ophthalmology
Association of University Radiologists
Child Neurology Society
Coalition for Health Funding
Conjoint Committee for Diagnostic Radiology
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Digestive Disease National Coalition
Dystrophic Epidermolysis Bullosa Research Association of America
Endocrine Society
Epilepsy Foundation of America
ESA, Inc.
Federation of American Societies for Experimental Biology
Gerontological Society of America
Health Industry Manufacturers of America
Infectious Diseases Society of America
Joint Council of Allergy and Immunology
Juvenile Diabetes Foundation
Leukemia Society of America
Lupus Foundation of America
National Association for Biomedical Research
National Association of Private Psychiatric Hospitals
National Association of State Universities and Land Grant Colleges
National Coalition for Cancer Research
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Sudden Infant Death Syndrome Foundation
Orthopaedic Research Society
Society for Investigative Dermatology
Society for Neuroscience
Society for Pediatric Research
Society of Academic Anesthesia Chairmen
Society of Critical Care Medicine
Society of Nuclear Medicine
Society of Teachers of Emergency Medicine
Society of Teachers of Family Medicine
Society of University Urologists
University Association for Emergency Medicine

LETTER FROM JULEE H. KRYDER-COE, THE JOHNS HOPKINS UNIVERSITY INSTITUTE FOR POLICY STUDIES

May 15, 1989

The Honorable Thomas Harkin
Chairman
Senate Appropriations Subcommittee
on Labor, Health, and Human Services,
Education and Related Agencies
Senate Office Building, Room 186
Washington, D.C. 20510

Dear Chairman Harkin:

I am writing to apprise you, the ranking minority member, Mr. Specter, and subcommittee members, of a recent national conference focused on the growing problem of child and youth homelessness. Sponsored by The Johns Hopkins University Institute for Policy Studies and entitled: "Homeless Children and

Youth: Coping with a National Tragedy", the conference pulled together for the first-time on April 25-28, 1989 in Washington, D.C. the leading researchers, policy-makers, advocates, services providers and foundation and corporate leaders to comprehensively examine the problems of homeless children and youth and to explore policy and program alternatives to reduce the incidence of homelessness among young people in the United States. The conference focused on two populations with differing needs and solutions: very young children (infants, pre-schoolers, and school-age children) who are part of a homeless family and, older young people who are homeless but on their own (pregnant teens and teen parents, runaways, and other adolescents). Twelve research and policy papers were commissioned for presentation and dissemination at the conference to: explore the scope of the problem among both populations of our youth; review the health, mental health, developmental and educational consequences; examine the causes of the problem in society, the economy and the housing market; analyze the response of current public policy to the problem in terms of housing, child welfare and welfare policy; and, offer policy and program options at the federal, state and local level to reduce child and youth homelessness.

Among the key findings presented in conference papers were the following:

1. The Scope of the Problem Among Younger Homeless Children: Families are the largest growing segment of the homeless population making up just over one third[1]; 100,000 American children go to sleep homeless every night[2]; Because emergency shelters are a last resort, many families are among the "hidden homeless" - those doubled or tripled up with other housed families, those living in cars, campgrounds or other unconventional settings, and families in which parents and children have been separated by homelessness - for example, New York City estimates that 40-60% of its assisted housing units are occupied by more than one family[3]; in 1988, 68% of 29 major U.S. cities surveyed by the U.S. Conference of Mayors reported turning away families.[4]

2. The Scope of the Problem Among Older Youth on Their Own: In 1982, there were between 733,000 and 1.3 million runaway and homeless youth[5]; Homeless youth are both male and female, between 13 and 17, "local kids", had interrupted or difficult school histories, showed a history of homelessness (79.3% had been homeless more than once, 25% had been homeless more than ten times)[6], have multiple problems; young people are homeless because of, a.) a variety of family problems including being "evicted" from home, family conflict or communication problems, an inability to return home, neglect, physical and sexual abuse, and a history of alcohol problems in

the family; b.) residential instability, including extensive moves and separations, family disruptions and institutional interventions (lack of out-of-home resources; foster care and group homes and "aging out" of foster care) - for example, 2.5% of children existing in the child welfare system ran away during 1985[7]; In a study of independent living experiences of youth who had been out of foster care for a minimum of two years, one in three spent their first night on the streets, the average number of living situations for these young people was six and 29% had periods of homelessness and/or weekly moves[8]; c.) socio-economic causes - family economics, lack of affordable housing.

3. The Health Impacts on Homeless Children and Youth: Homeless children receiving care through the National Health Care for the Homeless Program had twice the rate of anemas and upper respiratory infections for normal children[9]; homeless children were found to have health problems in the fair or poor range, which is four times higher than in the general pediatric population and had a high prevalence of immunization delays[10]; 14% of homeless girls who visited Health Care for the Homeless were pregnant[11].

4. The Developmental and Educational Impacts: 47% of homeless children in Boston exhibit at least one developmental lag (language delays, personal and social development, gross and fine motor skills) and 33% have two or more[12]; 31% of homeless children are clinically depressed[13]; 66% of homeless boys and 50% of homeless girls had behavioral problems requiring psychiatric evaluation[14]; 30% of homeless children do not attend school[15]; 43% of homeless school-age children in Boston were failing or performing below average work[16]; 57.7% of homeless children in New York scored below grade level in reading power and 71.9% scored below grade level in math[17];

5. Causes of Child and Youth Homelessness: The reduction in the availability of low-income housing units and insufficient income are the driving forces behind much family homelessness[18]; in twelve major metropolitan housing markets examined during 1978-1983, the number of families in poverty rose by 36% while the number of rental units affordable to them fell by about 30%[19]; 22.3 million households pay 30% or more of their income for housing, 9.3 million pay half or more, 3.6 million renters pay more than 70% of their income for housing[20]; 5.4 million households are served by all federal housing programs (less than 1/3 of those eligible)[21]; the waiting list for public housing in New York is now 18 years long[22].

"Homeless families do not demonstrate specific economic differentials from other members of the surveyed very poor who managed to avoid homelessness"[23]; from 1975 to 1985, poverty grew by 13.8%[24]; 33% of eligible homeless families actually receive aid to families with dependent children (AFDC)[25].

A variety of policy and program options to reduce child and youth homelessness were presented at the conference. Beginning approaches in housing, welfare and child welfare policy included:

- Support for various housing supports as per current Congressional legislation including: 1) H.R. 1180 which would reauthorize existing housing and community development programs at a slightly higher level than they are now funded; 2) H.R. 140 (Permanent Housing for the Homeless Act), 3) S.565 (National Affordable Housing Act) which offers a more flexible approach to the funding and delivery of federal low-income housing assistance in the United States; 4) H.R. 973 - would provide $20 billion new dollars for low-income housing production for each of the next five years; 5) H.R. 969, which authorizes the construction and preservation of 600,000 public housing units per year for the next ten years; 6) H.R. 1122 which would provide $35 billion in new spending authority for the public sector to buy out private landlords and other property owners for the benefit of the poor;
- Full funding of existing programs, such as Head Start and WIC, the nutritional program for pregnant women, infants, and children, which currently serves only a small proportion of those who qualify;
- An increase in the minimum wage and the earned income tax credit, and a redefining the poverty level to include cash benefits only and to be determined by geographic location;
- Coordination of services offered by government agencies that are often competitive and engage in battles for scarce funds;
- Community-based, culturally appropriate services--especially for homeless adolescents--that strengthen families;
- A campaign to apprise political leaders of economic consequences of homelessness in addition to its moral and ethical aspects.

To summarize, with families now the fastest-growing segment of the homeless population, we may well be creating an even larger homeless population for the future. Homelessness among children and youth goes well beyond housing problems, and the health, mental health, developmental and educational consequences of this homelessness on children suggests an impaired future adult population which will comprise an inadequate future work force and will have difficulty serving as productive members of society.

The answer to homelessness is not improved shelters but a comprehensive approach which embodies generating an adequate supply of permanent, affordable housing, full employment and adequate income maintenance programs.

A comprehensive set of policy recommendations from the conference are being prepared for release in June, 1989.

Thank you for this important opportunity to share information from this important national conference. (A complete listing of the conference's commissioned papers is appended.)

Yours Truly,

Julee Kryder-Coe

Julee H. Kryder-Coe
Coordinator of Special Programs
Institute for Policy Studies
The Johns Hopkins University

STATEMENT OF HON. JOSEPH I. LIEBERMAN, U.S. SENATOR FROM CONNECTICUT

Mr. Chairman, Members of the Subcommittee, I am pleased to testify today in support of the Impact Aid program. This program provides critical federal assistance to those school districts which serve children whose parents live and/or work on federal property.

Impact aid ensures that the affected communities can afford to provide federally-connected children with the quality education to which they are entitled. Impact aid is an in-lieu-of tax payment. Most school districts support themselves by taxes on the property of private individuals and by taxes on property used for business purposes. When a child's parents live and work on a military base, the child may attend public school but the school receives no tax dollars from the family or the employer. School districts rely on federal funds to replace the taxes which they do not receive and allow them to continue providing all children in the district with the best education possible.

In Groton, Connecticut 45% of the students are federally-connected, 37% of these children have parents who live and work on federal property. These children come from the naval base located in Groton. They are children who may have had a transient educational history, moving from one school to another often in the middle of the year. Not only does the Groton school system provide these children with a quality education, but it provides special services to facilitate their adjustment to a new school and a new community.

In order to provide special services to these children, the Groton public schools must hire additional teachers and teachers aides and it must have the funds to pay them. Furthermore, Groton has established a computer system with which it is able to communicate with the schools these military-connected children most often come from. This computer link enables Groton to obtain needed educational information on these children before they arrive. It ensures that the children can be immediately placed in the proper classes and connected with their favorite extracurricular activities. This information eases what could be a difficult transition; however, establishing and maintaining this computer system costs money.

In fiscal 1989 246 additional federally-connected students arrived in the Groton schools; Groton received no funds for these students because the funding has been capped at the 1987 level.

I want to emphasize to the Subcommittee the importance of these funds to the Groton school system and other school systems like it. We have a duty to provide the children of military families with quality educations and a responsibility to ensure that local school systems are able to serve these children well. I encourage the Subcommittee to ensure that the Impact Aid program is adequately funded in fiscal 1990 and that school systems receive funds for every federally-connected child who attends their schools.

STATEMENT OF HON. TOM DASCHLE, U.S. SENATOR FROM SOUTH DAKOTA

Mr. Chairman, I appreciate having the opportunity to share my perspective on the vital role of Impact Aid in South Dakota. Impact Aid plays an essential role in the education of the children of South Dakota, and I want to do all I can to assist your efforts to strengthen this critical federal program.

Impact Aid (PL 81-874) provides school districts that have been precluded from collecting taxes because of a federal presence with the resources necessary to provide federally connected children a basic free public education. We have a responsibility to these schools that are impacted by federal activities and which have been led to believe that they will receive help for their students.

South Dakota relies heavily on Impact Aid funds to meet the basic educational needs of both Indian and military students. There are approximately 40 school districts in South Dakota receiving funding under the Impact Aid program. Over 25 percent of these districts depend on Impact Aid for 50 percent or more of their operating budgets and the quality of their educational programs. These districts received over $14 million in federal Impact Funds last year.

Impact Aid districts have had to struggle to receive the basic payments to run their school programs. The result has been that Impact Aid districts have been forced to struggle for scarce and inadequate resources and that, in many cases, the basic education needs of children have not been met.

The continual erosion of Impact Aid funds has drastically reduced these school districts' ability to provide a quality education to the students in South Dakota. I recently had the opportunity to visit Douglas School District, which serves Ellsworth Air Force Base, to see firsthand the difficulties facing this district. Doulgas has had to close its doors on one occasion and has had to suspend teacher contracts on another because of inadequate compensation. In addition, Douglas students often receive instruction in makeshift areas such as storage and supply rooms, corridors, and temporary facilities which include a remote, renovated Nike missile site.

Todd County School District, which serves a significant number of Indian students, is another example of the adverse consequences of inadequate Impact Aid funds. In order to address the significant shortfall in funds, this school district has been forced to reduce the teaching staff and aide staff, suspend capital outlay expenditures for the year, and cut back on textbooks and other supplies.

Over the past year, I have met with numerous other school superintendents from South Dakota who are deeply concerned about the funding level for Impact Aid. Every year, they face an uphill battle in trying to secure the necessary funds to provide a basic free public education for the students in their district. I believe we need to give them the confidence that the government will follow through on its pledge of support for federally connected students.

Your committee plays a critical role in ensuring that the basic educational needs of Indian and military children in my state and throughout the country are met. I would strongly urge you to appropriate the full authorization level of $785 million for PL 81-874. Full funding of Impact Aid is the only way we can assure children in federally impacted school districts the educational opportunities they deserve. Our children deserve nothing less.

Once again, I thank you for your continued interest in this program.

STATEMENT OF HON. LLOYD BENTSEN, U.S. SENATOR FROM TEXAS

Mr. Chairman, Members of the Committee, I appreciate the opportunity to present my views about and express my support for the Impact Aid program. This vital program serves over 2,000,000 children across the nation; 35 percent of whom are dependents of active-duty military personnel.

While other federally-funded education programs offer supplemental extras, Impact Aid offers nothing other than reimbursements to local schools for the burden of educating federally-impacted children. The funds are used to pay teacher salaries, buy instructional supplies and purchase necessary furniture required in the education environment. The reimbursement should cover the cost to local schools of educating children placed there by the federal government, as they receive less local revenue and more students due to federal activity in their community.

In Texas, the federal government operates nine major military installations. Together, these bases brought in almost 41,000 extra military independent students last year with an additional 3500 expected over the next few years. The local schools bear the burden of placing and educating these students but the bases themselves are exempt from local school taxes. The federal government is obligated to pay for the education of these children, not the community surrounding the military base. Impact Aid is used to bridge this obvious gap between community-provided funds and the needs created by the military children.

Without this reimbursement program, many school systems would come to an abrupt halt. Property taxes are one of the few ways that schools districts can raise money. When the federal government removes a large land area from the tax rolls and then imports thousands of students into the surrounding community, we must provide repayment for the service we are requiring them to provide. The local communities should not be required to raise their taxes to pay for federal activities.

The Impact Aid program requires and deserves our strong support. As this Committee confronts the difficult spending decisions for Fiscal Year 1990, I urge you to give this program a high funding priority and fund it at a level consistent with its undeniable importance. Spending for the Impact Aid program is authorized for Fiscal Year 1990 at $735 million, a benchmark we should strive to reach.

STATEMENT OF HON. SLADE GORTON, U.S. SENATOR FROM WASHINGTON

I AM WRITING TO YOU IN SUPPORT OF FUNDING FOR THE FEDERAL IMPACT AID PROGRAM (P.L. 81-374 AND P.L. 81-815), PARTICULARLY FUNDING FOR THE "B" STUDENTS.

IMPACT AID FUNDS ARE VITAL TO MY HOME STATE OF WASHINGTON: IN FY88, WASHINGTON SCHOOLS RECEIVED $26 MILLION DOLLARS IN IMPACT AID. NATIONALLY, IMPACT AID PAYMENTS FLOW TO 2,700 SCHOOL DISTRICTS IN 49 STATES, SERVING OVER 2 MILLION FEDERALLY-CONNECTED STUDENTS.

FUNDING OF THIS PROGRAM IS VITAL TO MAINTAINING QUALITY EDUCATION FOR DISTRICTS WITH LARGE NUMBERS OF FEDERALLY-CONNECTED STUDENTS.

AS YOU KNOW, THE ADMINISTRATION REQUESTED $629.3 MILLION FOR FY90 FUNDING OF IMPACT AID, $103.8 MILLION LESS THAN THE FY89 APPROPRIATIONS LEVEL OF $733.1 MILLION. A SUBSTANTIAL PORTION OF THE "SAVINGS" PROPOSED BY THE ADMINISTRATION COMES FROM THEIR DESIRE TO ELIMINATE THE "B" CATEGORY STUDENTS.

I UNDERSTAND WHY THE ADMINISTRATION HAS PROPOSED ELIMINATING FUNDING FOR THE "B'S": THE ADMINISTRATION IS CONCERNED ABOUT SPENDING AND IS SEARCHING FOR WAYS TO BRING THE DEFICIT DOWN. I APPLAUD ITS CONCERN, BECAUSE IT SHOWS RESPONSIBILITY AND A COMMITMENT TO THE AMERICAN TAXPAYER.

BUT I MUST DISAGREE WITH THE SUGGESTION THAT IT IS RESPONSIBLE TO REDUCE IMPACT AID FUNDING FOR THE PURPOSE OF REDUCING THE FEDERAL DEFICIT. IN FACT, IT IS VERY IRRESPONSIBLE, BOTH BECAUSE IT WILL HARM THE EDUCATION RECEIVED BY CHILDREN OF FEDERALLY-CONNECTED FAMILIES AND BECAUSE THE GOVERNMENT WOULD BE SHIRKING ITS DUTY TO THOSE COMMUNITIES WHICH HAVE LARGE FEDERAL INSTALLATIONS.

NO ONE QUESTIONS THE PRINCIPLE THAT THE FEDERAL GOVERNMENT SHOULD COMPENSATE LOCAL SCHOOL DISTRICTS FOR "A" STUDENTS, THOSE WHOSE PARENTS BOTH LIVE AND WORK ON FEDERAL INSTALLATIONS. CLEARLY, THESE STUDENTS BECOME A FINANCIAL BURDEN TO THOSE COMMUNITIES THAT THE FEDERAL GOVERNMENT MUST BE RESPONSIBLE FOR.

BUT SHOULD THE FEDERAL GOVERNMENT FINANCIALLY REIMBURSE SCHOOL DISTRICTS FOR "B" STUDENTS, THOSE WHOSE PARENTS WORK ON FEDERAL INSTALLATIONS BUT LIVE IN THE COMMUNITY? TO ANSWER THAT QUESTION, IT IS FIRST NECESSARY TO UNDERSTAND THE IMPACT THESE "B" STUDENTS HAVE ON THEIR SCHOOLS.

THE SPECIAL NEEDS OF FEDERALLY-CONNECTED STUDENTS REQUIRE A SCHOOL TO GEAR PROGRAMS TO QUICKLY ASSESS A CHILD'S EDUCATIONAL LEVEL, PROVIDE REMEDIAL OR ADVANCED TEACHING, AND HELP THESE

STUDENTS TO ACCLIMATIZE RAPIDLY TO THEIR NEW LEARNING ENVIRONMENT. TURNOVER RATES AMONG SOME SCHOOLS SERVING MILITARY INSTALLATIONS IN WASHINGTON ARE MORE THAN 70%, MEANING THAT THERE IS A CONSTANT NEED TO PROVIDE STUDENTS WITH THESE SPECIAL SERVICES. THIS PLACES AN EXTRAORDINARY BURDEN ON THESE SCHOOLS TO PROVIDE QUALITY EDUCATION TO BOTH MILITARY AND NON-MILITARY CHILDREN.

THIS IS JUST AS TRUE FOR SCHOOLS WITH "B" STUDENTS AS IT IS FOR SCHOOLS WITH "A" STUDENTS: A CHILD HAS NO LESS NEED FOR A GOOD EDUCATION JUST BECAUSE HIS OR HER FAMILY DOES NOT LIVE ON FEDERAL PROPERTY. THERE IS STILL THE PROBLEM OF HIGH TURNOVER. THERE IS STILL THE PROBLEM OF PROPERTY REMOVED FROM THE TAX ROLLS BECAUSE OF FEDERAL GOVERNMENT NEEDS. THERE IS STILL FEDERAL GOVERNMENT RESPONSIBILITY.

CERTAINLY, COMPENSATION FOR "B" STUDENT SHOULD BE LESS THAN THAT FOR THE "A" STUDENT. SINCE "B" FAMILIES LIVE OFF-BASE, THEY DO GENERATE SOME PROPERTY TAX REVENUE TO THE SCHOOL DISTRICT THAT "A" FAMILIES DO NOT. BUT THAT DOES NOT LESSEN THE FACT THAT THE FEDERAL GOVERNMENT HAS REMOVED OTHER PROPERTY FROM BEING TAXED AND THE FEDERAL GOVERNMENT IS RESPONSIBLE FOR THE PRESENCE OF THE "B" STUDENTS.

TO GIVE YOU AN IDEA OF WHAT IT WOULD MEAN TO ELIMINATE "B" STUDENTS FROM THE IMPACT AID PROGRAM, LET ME USE MY STATE AS AN EXAMPLE. IF FUNDING FOR "B" STUDENTS IS ELIMINATED, OVER A THIRD OF THE SCHOOL DISTRICTS IN WASHINGTON WOULD BE IN SOME WAY AFFECTED: 89 DIFFERENT SCHOOL DISTRICTS WOULD LOSE A TOTAL OF $4 MILLION, AFFECTING 49,000 STUDENTS. ELIMINATION OF "B" STUDENT FUNDING WOULD HAVE A DEVASTATING AFFECT ON EDUCATION IN STATES WITH LARGE FEDERAL INSTALLATIONS.

AS COMMITTED AS I AM TO REDUCING THE FEDERAL DEFICIT, I CANNOT SUPPORT THE ADMINISTRATION'S PROPOSAL TO ELIMINATE PAYMENT FOR

"B" STUDENTS, NOR THE LOWER LEVEL OF OVERALL FUNDING FOR IMPACT AID. TO DO SO WOULD BE PENNY-WISE AND DOLLAR FOOLISH. IT WOULD ALSO BE UNFAIR, BOTH TO THE INDIVIDUAL STUDENTS INVOLVED AND TO THE COMMUNITIES WHO ARE ATTEMPTING TO BE GOOD NEIGHBORS TO THE FEDERAL INSTALLATIONS WITHIN THEIR BOUNDARIES.

WHILE YOU ARE CONSIDERING THE VARIOUS EDUCATIONAL NEEDS OF AMERICA'S SCHOOLS, PLEASE GIVE CONSIDERATION TO THE SPECIAL NEEDS OF THESE FEDERALLY-CONNECTED STUDENTS AND THE SCHOOL DISTRICTS THAT SERVE THEM.

LETTER FROM MERRILY DEAN BAKER, THE NATIONAL COLLEGIATE ATHLETIC ASSOCIATION

June 8, 1989

The Honorable Tom Harkin
Chairman
Appropriations Subcommittee on Labor,
HHS, Education and Related Agencies
United States Senate
186 Dirksen Senate Office Building
Washington, D.C. 20510-6034

Dear Senator Harkin:

When Vivian L. Fuller testified on behalf of the National Collegiate Athletic Association (NCAA) before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies on May 12, 1989, you requested information concerning:

1. The amount of money the NCAA contributed to the National Youth Sports Program (NYSP) last year (FY 1989), and
2. The amount the NCAA is willing to contribute to NYSP next year (FY 1990).

The approved budget for the FY 1989 NYSP provides for NCAA expenditures in the amount of $356,130, for personnel, travel, supplies, legal services, office space, telephone costs and postage.

For FY 1990, the NCAA is willing to increase its expenditures for NYSP in proportion to any increase in Federal appropriations for the program approved by the Congress.

In considering sources of support for this outstanding program, it is important to recognize that the non-Federal contribution to NYSP the NCAA helps to generate far exceeds the amount set forth above. The contribution includes sports equipment and shirts provided to NYSP by private corporations, including Rawlings Sporting Goods Company, Tachikara (a subsidiary of the Arch Billmire Company), and Penn Athletic Products, as a requirement of licensing agreements with the NCAA. In FY 1989, these contributions will consist of items such as basketballs, footballs, volleyballs, tennis balls and staff shirts; the total value of the contributions is more than $355,148.

In addition, in FY 1989, the colleges and universities participating in NYSP (of which approximately two-thirds are NCAA member institutions) will contribute staff, facilities, equipment and other resources at a value of $14,195,065. Private businesses and local and state governments will make an additional $3,291,982 in contributions. The sum of the budgeted non-Federal contributions to the FY 1989 NYSP from these sources is $17,842,195.

I hope this letter is responsive to your questions. We request that it be included in the record of the May 12, 1989, hearing.

Thank you for your interest in NYSP.

Sincerely yours,

Merrily Dean Baker

Merrily Dean Baker
Assistant Executive Director
for Administration

STATEMENT OF ROBERT M. TOBIAS, NATIONAL PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION

I am Robert M. Tobias, National President of the National Treasury Employees Union. NTEU is the exclusive representative of over 140,000 Federal employees, including workers in the Office of the Secretary, SSA's Office of Hearings and Appeals, Office of Human Development Services, Family Support Administration, and the ten regional offices of the Department of Health and Human Services. I am accompanied by Patrick Smith NTEU Director of Legislation, and Paul Suplizio legislative consultant.

I am pleased to appear before you to present NTEU's recommendation on the Administration's budget proposals for HHS for FY 1990. We believe this budget should be decisively rejected for the funding and personnel cuts it makes in a wide range of programs essential to the economic security and well-being of the American people. If this budget is approved, total HHS staff will decline from 121,796 FTE in FY 1987 to 114,000 FTE in FY 1990, a loss of 7,796 average positions. Virtually all of this reduction--7,777 average positions--will come from the Social Security Administration. We strongly oppose reductions proposed by the Administration for the Office for

Civil Rights, Social Security Administration, Family Support Administration, Office of Human Development Services, and the Public Health Service. Our alternative budget in Table 1 presents recommendations to restore these reductions.

The large cuts proposed in this budget for the Social Security Administration and Public Health Service, failure to provide the Office of Human Development Services with sufficient resources to alleviate the current hiring freeze, and continued inadequate staffing of the Family Support Administration are particularly irresponsible. Despite the impact of AIDS on the health professions and shortages of trained health professionals in many parts of the country, this budget cuts health professions grants by more than $200 million. Yet in SSA, billions in overpayments to beneficiaries are going uncollected from systems errors and inadequate staff. If SSA were given the resources to accelerate collection of these funds and prevent future errors, the additional revenue would allow HHS to staff components like OHDS and FSA to meet their rapidly growing responsibilities.

In FY 1990, OHDS will launch a major expansion of the Head Start program, while its child welfare and aging duties continue to expand. HCFA will implement the new Medicare Catastrophic Coverage Act, and FSA will implement the child support and work provisions of the new Family Support Act. The billions being spent on these programs to ameliorate dependency, hunger, and sickness will be ineffectual unless Congress provides sufficient resources for administration.

Most of the Department's activity centers around distributing Federal funds, and serving as a watchdog on whether those funds are being used properly. In a budget of $465 billion, serving 55 million beneficiaries, there is enormous potential for waste, fraud, and abuse if program management is not effective. The Inspector General identifies about $5 billion annually in sums that could be saved by better management. In areas like child health, foster care, adoption assistance, and programs for the elderly, Federal staff are required to oversee the use of funds by others. By saving the taxpayers' money, the Department's civil servants more than pay for themselves.

NTEU's alternative budget would sustain most HHS components at actual FY 1988 staffing levels. NTEU's total additions to the Administration's budget request for FY 1990 come to $800 million and 9,200 average positions. Of this increase, approximately $400 million and 8,200 average positions goes to restore SSA to full effectiveness, while most of the remainder is to restore proposed cutbacks in Health Resources and Services, namely, family planning and health professions grants. NTEU would add 166 positions to the Office of Human Development Services and 129 positions to the Family Support Administration. We strongly believe the proper course is for Congress to specify in the appropriations bill itself the level of staff to be maintained for each agency.

Social Security Administration

We are unalterably opposed to the Administration's plan to reduce SSA by 20,000 positions by 1990, and we call for full restoration of the 3,365 FTE cut planned for this year and next. Both GAO and SSA's own internal management surveys demonstrate that the agency has been gravely weakened by staff reductions, that error rates in processing and paying benefits are rising, that SSA is largely ineffectual in handling Medicare inquiries from the public, that the agency is plagued by morale problems due to downsizing and excessive use of statistical performance measures, and that skilled employees are exiting the service at an attrition rate of 9 percent. The Administration's downsizing plan is an attempt to achieve the Grace Commission's goal of dismantling the existing community-based service delivery system by shifting from face-to-face assistance to dealing with beneficiaries over the telephone. With the aging of our population, the number of persons contacting SSA each year--now more than 25 million--is steadily growing. We believe community-based service delivery should be strengthened as the backbone of the agency for the 1990's and the 21st century. This is a principal object of our "Service Now" Initiative which would add 5,650 positions at a cost of $165 million to SSA's budget for FY 1990. This increase would be over and above full restoration of the 3,365 positions earmarked for reduction in FY 1988 and FY 1989.

Office of Human Development Services

OHDS is one of the most seriously understaffed components of HHS, yet the agency is presently in a hiring freeze and leaving positions unfilled because of a budget shortfall for FY 1989. HHS has requested Congress to permit reprogramming $1.6 million to tide OHDS over for 1989, but after discussions with HHS budget officials NTEU believes $2.3 million is necessary. We strongly support the authority to reprogram this amount. Looking to 1990, OHDS is scheduled to lose 21 additional FTE if the Administration's budget is approved. Our alternative budget restores these positions and adds 145 new positions to deal with the agency's growing workload in child welfare, developmental disabilities, problems of aging, and the major expansion of Head Start.

Family Support Administration

The Offices of Family Assistance and Child Support Enforcement are confronted with rising workloads due to the implementation of the new Family Support Act, the advent of new child support enforcement tools, a new Income Eligibility Verification System and Child Support Enforcement Network, and measures aimed at reducing AFDC program costs. In view of this growing worklad and the passage of welfare reform that will add many new tasks, OFA staff should be increased to maintain effective program administration.

TABLE 1. DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET FOR FY 1990 AND NTEU RECOMMENDATION

	FY 1988 Actual		FY 1989 Appropriation		FY 1990 Request		FY 1990 NTEU Proposal (Changes)		FY 1990 NTEU Recommendation	
	($000) Amount	FTE	($000) Amount	FTE	($000) Amount	FTE	($000) Amount	FTE	($000) Amount	FTE
Departmental Management[1]	137,840	1,716	140,179	1,741	149,235	1,741	--[a]	--	149,235	1,741
Office for Civil Rights	16,343	344	15,979	325	17,567	325	+ 796[b]	+ 19	18,363	344
Social Security Administration[2]	3,524,114	66,372	3,750,113	64,599	3,833,389	63,007	+392,711[c]	+8,242	4,226,100	71,249
Family Support Administration[3]	76,773	983	75,760	1,017	75,431	1,029	+ 5,552[d]	+ 129	80,983	1,158
Health Care Financing Administration[4]	98,211	3,812	93,284	4,017	102,908	4,017	+ 4,148[e]	+ 100	99,394	4,117
Office of Human Development Services[5]	64,368	1,025	65,015	1,004	69,074	1,004	+ 9,852[f]	+ 166	78,926	1,170
Health Resources and Services Administration	1,336,265	1,826	1,612,993	1,641	1,203,568	1,498	+373,179[g]	+ 373	1,576,747	1,871
Centers for Disease Control	515,434	3,947	599,629	4,073	573,558	4,167	+ 2,341[h]	+ 18	575,899	4,185
Alcohol, Drug Abuse, and Mental Health Administration[6]	1,261,470	1,700	1,670,226	1,693	1,624,316	1,804	--	--	1,624,316	1,804
Food and Drug Administration	477,504	7,039	541,906	7,165	512,792	7,322	+6,050[i]	+126	518,842	7,448
Assistant Secretary for Health	193,025	546	194,210	554	186,844	526	+3,986[j]	+ 37	190,830	563
TOTAL RECOMMENDED ADDITIONS							+798,615	+9,210		

1. Includes Direct Appropriation and Working Capital Fund
2. Limitation on Administrative Expenses
3. Program Administration
4. Program Management
5. Program Direction
6. Excluding St. Elizabeth's Hospital

FOOTNOTES

a. No change is proposed for General Departmental Management. Office of the Secretary units are increased a total of 25 positions in FY 1989 and this increase is maintained in FY 1990. Offices gaining positions include Immediate Office of the Secretary, Public Affairs, Legislation, Planning and Evaluation, Personnel Administration, and Field Management.

b. For Office of Civil Rights, $796,000 and 19 FTE are provided to maintain the level of 344 FTE achieved in FY 1988.

c. For Social Security Administration, NTEU recommends an FY 1989 supplemental of $161.7 million and 1,000 FTE to maintain the level of 66,045 FTE mandated by Congress. For FY 1990, NTEU adds $227.7 million and 2,592 FTE to maintain FY 1988 service levels, plus a "Service Now" Initiative of $165 million and 5,650 FTE. Total NTEU additions for FY 1990 are $392.7 million and 8,242 FTE. These positions are justified in a separate statement.

d. For Family Support Administration, 29 FTE and $1,248,189 are added to maintain the FY 1988 level approved by Congress (1046 FTE). The FY 1989 operating budget reduces FSA to 1017 FTE because of required cost absorptions, so addition of 29 FTE would maintain the FY 1988 level. An additional 100 FTE are provided at a cost of $4.3 million to strengthen welfare and child support enforcement program administration, improve program data and assessment of program effectiveness in Child Support Enforcement (this was a GAO recommendation), implement the new Family Support Act, and strengthen the Office of Community Service's administration of the Community Services Block Grant and Community Food and Nutrition Progams.

e. For Health Care Financing Administration, the President's budget request includes an increase of 75 FTE's and $3.1 million to support the new prescription drug provisions of the new Catastrophic Health Insurance program. NTEU provides an additional 100 FTE at a cost of $4.1 million to strengthen HCFA's abililty to implement several new health cost containment initiatives in the President's budget, and to improve HCFA's oversight over private contractors who receive billions in Medicare and Medicaid funds.

f. For Human Development Services, includes addition of 21 FTE and $958,000 to maintain FY 1988 level appropriated by Congress, plus $2.3 million to offset required cost absorptions for FY 1989 that have necessitated a hiring freeze. An additional 145 positions for the Administration for Children, Youth, and Families, Administration on Aging, Administration for Developmental Disabilities, and Administration for Native Americans are also provided. These agencies remain seriously understaffed relative to their important functions, and must implement a greatly enlarged Head Start program, new Developmental Disabilities Act and Older Americans Act amendments, and increased child welfare responsibilities.

g. For the HRSA account, the Administration proposes program reductions totaling $359 million, mainly in Family Planning ($138 million) and Health Professions Grants ($208 million). In addition, 373 FTE costing $14 million are cut from program management. Congress has refused to go along with these cutbacks in the past, and we support their restoration. Accordingly, NTEU recommends addition of 373 FTE and $373 million to the budget request.

h. For CDC, NTEU restores 18 FTE and $2.3 million claimed as management improvements to offset the cost of the 1989 pay increase.

i. FDA's budget request includes 183 new positions for AIDS-related work. There is also a claimed 26-position management saving, which is not justified in the budget and is restored in our recommendation. NTEU also adds 100 positions to permit FDA to speed medical device and drug reviews, deal with the problem of pesticides in the food supply, upgrade surveillance of imported foods, process and analyze the large volume of reports received from manufacturers under the Medical Device reporting regulation, and institute compliance inspections of medical device manufacturers as recommended by GAO.

j. For OASH, NTEU restores proposed cuts of $4 million and 37 FTE in the adolescent family life, family planning, and physical fitness programs.

STATEMENT OF THE ASSOCIATION OF AMERICAN UNIVERSITIES

Graduate education makes essential contributions to our economic competitiveness, national security, and to the health of our citizens and the quality of their lives. The United States invested an estimated $132 billion in R&D in FY 1989. R&D could not occur without graduate education. Graduate programs educate the scientists and engineers needed by industry, government, and universities. The United States has built the largest, most accessible higher education system in the world. In 1988, over 12 million students attended U.S. colleges and universities. These institutions employ over 700,000 faculty. Two-thirds of them hold doctorate degrees. The reach of graduate education extends beyond the university: fifty percent of 1987 doctorate recipients had employment commitments outside academia.[1]

The stability and quality of U.S. graduate education is about to be severely challenged. Beginning in the mid-1990s, an increased rate of faculty departures will collide with a growing demand for teaching faculty generated by expanding enrollments. The sharp increase in demand

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1. National Research Council, *Summary Report 1987, Doctorate Recipients from United States Universities*. Washington, DC: National Academy Press, 1989.

for faculty will be superimposed on a growing demand for Ph.D.s in nonacademic markets. A recent analysis has shown that current trends will result in an annual shortfall of 7,500 Ph.D.s in the natural science and engineering just a few years into the next century.[2] Increased demand for Ph.D.s in humanities and related fields will produce a shortfall in those fields as well. Absent concerted action, universities, government, and industry will soon be pitted against each other in an intensified competition that will ill-serve the nation no matter who wins.

Are current policies adequate to meet increasing demand? There is clear and compelling evidence that the answer is no. Two trends are working against the capacity of universities to meet an increased demand for doctorate recipients: (1) the declining number of Ph.D.s earned by U.S. citizens, and (2) the continued underrepresentation of minorities and women.

Declining Number of U.S. Doctorates: The number of U.S. citizens receiving doctorates has declined steadily, offset by increased numbers of foreign Ph.D.s. In 1970, 84.5% of doctorate recipients were U.S. citizens. By 1986, the percentage of U.S. citizens receiving doctorates had dropped to 72.3%. The shift from U.S. to foreign students has been even greater in science and engineering fields. In the physical sciences, U.S. doctorate recipients dropped from 82.2% in 1970 to 62.5% in 1986; in engineering, the drop was from 73.2% to 40.8%.

That so many foreign students are enrolling in U.S. graduate programs testifies to the quality of those programs. The infusion of talented students from other nations strengthens our graduate programs and enriches this country's intellectual resources. But it is unwise national policy to rely so heavily on imported talent and fail to develop our own intellectual resources.

Underrepresentation of Minorities and Women: Between the late 1950s and early 1970s, the participation in graduate programs by underrepresented groups–non-Asian minorities and women–increased substantially. The increases of several of these groups have not been sustained or have been followed by actual declines. In 1987, 765 blacks earned Ph.D.s. That represents 4.5% of total Ph.D.s awarded, substantially less than their 12% representation in the general population. Hispanics, who make up 6.5% of the population, received 2.8% of 1987 Ph.D.s. Underrepresentation of women and minorities is particularly severe in the physical sciences and engineering. Blacks received less than 1% of the Ph.D.s awarded to U.S. citizens in the physical sciences and engineering in 1987. Women earned over 35% of total Ph.D.s but only 6.5% of engineering Ph.D.s awarded that year.

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2. Atkinson, Richard C. "Supply and Demand for Science and Engineering Ph.D.s: A National Crisis in the Making." Remarks to the Regents of the University of California, February 16, 1989.

Supply and demand are moving in opposite directions in graduate education. The increased number of Ph.D.s the nation will require should be entering graduate school now. The Department of Education administers several programs which address the need to increase the number of U.S. students pursuing graduate degrees.

TITLE IX, GRADUATE EDUCATION

Two Title IX programs work in series to increase minority participation in graduate education. Grants to Institutions to Encourage Minority Participation in Graduate Education (Part A) is a proven model for increasing the size of the undergraduate pool of minority students interested in and qualified for graduate study. The Patricia Roberts Harris Graduate Fellowship Program (Part B) is the largest federal program providing fellowship support for postbaccalaureate study to students from groups underrepresented in graduate and professional education.

The minority research internship program provides summer research internships and related education activities to talented minority *undergraduates*, to interest them in and prepare them for graduate study. The program has received its second year funding of $3.5 million in FY 1989, up from $3.4 million in FY 1988. Because of the critical need to increase minority graduate enrollments, we ask that funding for the Part A program be increased from $3.5 million to $5.0 million for FY 1990. This amount would permit the program to support an estimated 1,500 students, still less than 2% of the roughly 80,000 college graduates per year from the targeted minority groups.

We request $23.3 million in FY 1990 appropriations for the Harris graduate fellowship program in order to provide for a new class of 800 students, restore the program to its FY 1986 funding level, and expand opportunities for minorities and women to pursue postbaccalaureate study.

We request an inflationary increase to $3.4 million for the Patricia Roberts Harris Public Service Fellowship program, a separately appropriated program under Title IX-B which provides support for students pursuing graduate study in public service programs such as public administration, social work, and other social service programs.

The Jacob K. Javits Fellows Program (Part C) is the only federally funded program providing fellowship support for graduate study in the arts and the humanities, and is one of few programs providing a small amount of support in the social sciences. In addition to supporting continuing fellowships, the FY 1989 funding of $7.9 million will fund a new class of 120 students, down from the 211 new fellowships awarded in FY 1988. We request $8.4 million for the Javits program for FY 1990 to support a new class of 200 students in addition to funding continuing fellows.

When U.S. preeminence in science and technology was challenged in 1957 by the launching of Sputnik, the federal government responded with sharply increased funding for graduate education and research. The response succeeded, increasing both the size and quality of university research and graduate education programs.

Thirty years later, a similar effort is required. Graduate Assistance in Areas of National Need (Part D) is designed to increase the number of this country's talented college graduates who elect to pursue careers in teaching and research in critical fields. We request an FY 1990 appropriation of $20.5 million for the National Need Program to fund a new class equal in size to the first year class of 510 and to support second and third year continuing fellowships.

With the requested FY 1990 appropriation, this program will have attained steady-state funding as a three-year traineeship program. From this point on, funds for new classes will be drawn from funds available from expiring traineeships.

TITLE VI, INTERNATIONAL STUDIES

The international studies programs of the Department of Education go to the heart of national imperatives for an internationally competitive economy, an informed foreign policy, and an internationally educated citizenry. The provision of a $14 million increase in Title VI programs could provide for a $10 million increase in the critical Language and Area Studies Centers and FLAS fellowships and an additional $4 million for important new programs authorized in the Higher Education Amendments of 1986 including advanced graduate fellowships, intensive summer language institutes, and language resource centers.

TITLE II RESEARCH LIBRARY PROGRAMS

Title II, Parts B, C, and D provide valuable resources for research libraries. Part B supports librarian training–focusing especially on attracting minority students into library schools. Grants through Parts C and D permit the nation's libraries to expand their collections of scholarly works, preserve those works that are threatened by deteriorating paper, facilitate access to unique collections through the acquisition of technological equipment supporting library resource sharing, and develop new techniques for expanding information services.

We request an FY 1990 appropriation for II-B and C programs that will at a minimum restore them to their former funding levels of $1 million and $6 million respectively. We request an inflationary increase for II-D to $3.8 million.

STATEMENT OF HENRY J. CAUTHEN, PRESIDENT, SOUTH CAROLINA ETV

America is in an education crisis. The education problem is especially acute in subject areas that directly affect our country's global competitiveness. I'm here to talk about a highly cost-effective solution to at least a major part of our education problem. It is a solution being implemented right now, today, as we talk. With your continuing support, we can positively influence the course of American education for generations.

The Satellite Educational Resources Consortium is completing a pilot semester that bears out our belief that STAR SCHOOLS can influence education's course for generations.

On January 17, 1989, SERC began broadcasting courses, live via satellite, to selected high schools in 18 states. The math, science, and foreign language courses were designed specifically to boost students' ability to compete in the global marketplace.

Teachers have also benefitted. The SERC project has let them improve their skills by taking college credit staff development courses without traveling from their schools.

Most importantly, through the use of powerful telecommunications technology, we've proven these courses can be made available, cost-effectively, to any school in the nation, no matter how rural or disadvantaged. For the first time, the American dream of equal education opportunity is within our grasp.

This historic education initiative is the result of several developments. The use of television for formal education was pioneered over 30 year ago. Although widely used today in many communities, instructional TV is often limited to the single broadcast channel of a local public tv station. Some multi-channel, closed-circuit systems are now in place that offer the diversity of programming needed for a number of courses in each grade. However, these systems are confined to individual states.

It was not until the development of regular television broadcast by satellite that live television instruction on a national scale became feasible.

In 1987, as Congress debated ways to regain America's global economic position, STAR SCHOOLS emerged. This proposal was welcomed by those involved with technology for education and support was given at hearings. The legislation that passed in 1988 would prove to be a major stimulus for a number of technology-based education initiatives across the country.

During this period, state public and educational broadcasting executives decided on a plan to pool resources and use the technology for education improvement. A national alliance was formalized between educational broadcasters and chief state school officers in a number of states.

The result is the Satellite Educational Resources Consortium or SERC. I co-chair SERC's governing board with Dr. Charlie Williams, South Carolina's superintendent of education. SERC now encompasses 19 states and the cities of Boston, Cleveland, Detroit, Kansas City, and New York.

During 1988, the consortium laid the groundwork for the January 1989 pilot project. SERC also applied for and received a 5.6 million dollar grant for the first year of STAR SCHOOLS. In effect, the SERC pilot project would be a testing ground for technology and teaching methods, so that STAR SCHOOLS can be smoothly implemented in the fall 1989 semester.

Courses for the pilot were carefully selected by educators based on need and lack of availability through traditional teaching methods. They include Probability and Statistics, produced by Kentucky Educational Television; Japanese I, produced by Nebraska ETV; and Advanced Placement Calculus for Teachers, a college credit telecourse produced by South Carolina ETV. Additional teacher in-service programming is provided by Wisconsin public broadcasting. Student courses are broadcast live each school day for Probability and Statistics, and three times a week for Japanese.

In a special feature of the project, made possible by modern telecommunications, instruction is truly interactive. Students communicate with instructors by means of telephone or electronic keypads. With digital keypads for example, the instructor can administer national pop quizzes, or query students in individual classrooms and receive responses in real time.

In the Japanese course, special times on Tuesdays and Thursdays are designated for each school when students can call for tutoring on toll-free numbers.

Through data transmission over satellite channels, standardized test forms and other support materials are fed to participating schools simultaneously with instructional broadcasts.

In September when the full STAR SCHOOLS program begins, the number of courses offered will expand. Tentatively scheduled for the fall semester are Advanced Placement Calculus for Teachers; Advanced Placement Economics for Teachers; Advanced Placement Economics (for students); Discrete Mathematics; Science, Technology and Society Seminars; Japanese I; Probability and Statistics; Russian I; and more teacher training courses.

In September, the number of participating schools will also greatly expand from the 58 high schools in the pilot project.

The schools chosen so far tend to be in rural areas, but some inner-city schools are participating as well. All have limited resources.

In some cases, local sponsors were recruited to help the schools take part in the project. In South Carolina for example, rural electric cooperatives provide schools with satellite receiving equipment, items not covered by SERC funding or the STAR SCHOOLS grant.

We need sustained federal funding, however, to significantly enhance and expand the education services offered by SERC.

The students in the pilot project were selected for their motivation to learn, particularly the important subjects not otherwise available in their schools.

The SERC pilot project will be completed this month, and evaluated this summer. Our present findings, we are sure, will be confirmed in the final analysis. STAR SCHOOLS is a visionary yet highly practical tool that can do much to boost our global academic standing. It is a means through which we can address our duty to provide equal education opportunity.

With STAR SCHOOLS, the best teaching resources will be within reach of all students and teachers, no matter their location or economic resources.

The nation that pioneered telecommunications will finally harness that technology to meet the challenges of a complex world.

STATEMENT OF THE NATIONAL EDUCATION ASSOCIATION

The National Education Association represents 1.9 million professional and support education employees throughout the nation in elementary, secondary, vocational, and postsecondary schools. We appreciate the opportunity to submit a statement about an issue that is fundamental to the future: appropriations for programs administered by the U.S. Department of Education for Fiscal Year 1990.

No program, no project, no activity of the federal government is more critical to our nation's future than education. The United States is its people. And inasmuch as federal education programs make a fundamental difference in the lives of millions of young people and adults, they deserve the resources necessary to carry out their objectives.

We commend this Subcommittee for its leadership in protecting elementary, secondary, and postsecondary education programs from the wholesale disinvestment recommended by the Reagan Administration over the past eight years. But, while Congress has protected education and related programs from the most severe cuts, there has been a devastating reduction in the level of assistance provided to public schools and students. Between FY80 and FY86, the federal share of the total resources provided elementary and secondary education fell from more than 9 percent to around 6 percent; it has remained frozen at that level for the past three years. During the same period, education's share of the total federal budget fell from 2.5 percent to 1.8 percent. If education programs were provided the same share of resources in FY90 as they were a decade before, there would be some $6.5 billion more available to restore service levels in needs-based education programs, and to fund new programs to continue the drive toward excellence in education.

After adjusting for inflation, Department of Education programs have lost more than $3 billion in resources. Elementary and secondary education programs alone have lost $4.2 billion after adjusting for inflation. And, given that the total resources reflect appropriations for programs that did not even exist in the 1980-81 school year, such as the Drug-Free Schools and Communities Act, the real loss to basic elementary and secondary education programs, including Chapter 1, bilingual education, impact aid, etc., is far greater than overall comparisons of funding levels reflect.

These reductions, through erosion from inflation and outright cuts, have resulted in a diminution of education services across the country and across the board. Compared to the 1980-81 school year, some 1.4 million fewer students are served in Chapter 1 compensatory education programs for disadvantaged students today; some 120,000 fewer students are served in bilingual education programs today; and the federal share of excess costs for handicapped education programs has fallen from 12 percent to 7 percent. We must end the erosion and begin to reinvest in our nation's future.

NEA is not alone in its belief that the federal government should be a full partner in the effort to expand access to quality educational opportunities for all students. Economists, business executives, military leaders, social scientists, in short, representatives from all walks of life have called for a renewed commitment to excellence in education. But for too many students and too many communities, educational opportunity is not possible without significant federal support and involvement. In particular, we are concerned about students who, because of factors related to their economic status, racial or ethnic background, geographic location, or because of human factors related to health, nutrition, and physical and psychological well-being are at risk of school failure. Estimates are that a full one-third of our nation's public school population are at risk because of some combination of these factors. Americans do know the solution. As the Committee for Economic Development pointed out in 1985, "An early and sustained intervention in lives of disadvantaged children both in school and out is our only hope for breaking the cycle of disaffection and despair." We have the knowledge. But too many states, too many communities, too many Americans are short on the resources.

NEA believes that the federal government, in partnership with state and local governments, with parents and others with a stake in public education's continued success, must establish and support programs that:

o address the human and developmental needs of preschool-aged children;

o meet the physical, emotional, and social needs of disadvantaged and other students at risk;

o encourage high standards for both students and educators;

o assist in the provision of diverse course offerings at all levels;

o provide resources to allow all qualified students an opportunity to pursue postsecondary education;

o stimulate education research and development; and

o create an environment conducive to lifelong learning for all Americans.

Earlier this year, NEA, with the assistance of Fiscal Planning Services, Inc., developed projections on what it would cost to fully fund four essential federal education programs: Chapter 1, handicapped education, bilingual education, and Pell Grants. In order to serve 100 percent of the students eligible for Chapter 1 and limited-English proficient students reported by states, to provide 40 percent of the excess costs of handicapped education, and to fund the full authorized maximum Pell Grant for current recipients would require an increase of $11 billion over

FY89 levels. In addition, to serve 100 percent of the students eligible for Head Start would cost another $6.3 billion over FY89 levels.

For most students who have had access to the programs, federal education services have been effective in accomplishing the purposes they were designed to carry out. The failure — in terms of our national goals of reaching all students and giving them them tools to be successful in school and in life — is not in the design, but in the fact these programs have never been provided funds adequate to serve all eligible students.

We call on you to provide at least $2.5 billion in additional funds for Department of Education programs in FY90 as a down payment on this vital investment in the future. NEA urges this Subcommittee to approve an FY90 Labor-Health and Human Services-Education Appropriation bill that would not cut any existing education programs; provide additional funds for all education and related programs to keep pace with inflation and enrollment increases; and provide additional resources to serve students currently eligible, but not served, in existing federal education and related programs, as well as to enable Congress to establish new programs to continue the national drive for excellence.

STATEMENT OF EDWARD J. KORMONDY, CHANCELLOR, UNIVERSITY OF HAWAII AT HILO

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY IN SUPPORT OF THE TITLE III PROGRAM. AS CHANCELLOR OF THE UNIVERSITY OF HAWAII AT HILO, I REPRESENT A CAMPUS THAT CURRENTLY ENROLLS NEARLY 3,700 STUDENTS WITH RESIDENTS OF THE ISLAND OF HAWAII MAKING UP 80% OF THAT NUMBER. ASIANS, PACIFIC ISLANDERS, HISPANICS, BLACKS, AND STUDENTS OF MIXED ETHINICITY MAKE UP 70% OF THE TOTAL ENROLLMENT. THE UNIVERSITY IS A UNIQUE ORGANIZATION THAT INTEGRATES A COMMUNITY COLLEGE, A COLLEGE OF ARTS AND SCIENCES, AND A COLLEGE OF AGRICULTURE. THE COMMUNITY COLLEGE GRANTS THE ASSOCIATE DEGREE, WHILE THE COLLEGE OF ARTS AND SCIENCES AND THE COLLEGE OF

AGRICULTURE GRANT BACCALAUREATE DEGREES IN BOTH ARTS AND SCIENCES. THIS DISTINCTIVE COMBINATION OF COLLEGES GIVES THE UNIVERSITY THE POTENTIAL TO PROVIDE A RICH VARIETY OF PROGRAMS AND SERVICES TO MEET THE NEEDS OF ITS DIVERSE STUDENT BODY.

IN ORDER TO FULFILL ITS POTENTIAL, THE UNIVERSITY APPLIED FOR AND RECEIVED A THREE YEAR TITLE III GRANT. WE ARE CURRENTLY IN THE SECOND YEAR OF THE GRANT. THE OVERALL FOCUS OF THE GRANT IS TO IMPROVE ADMINSITRATIVE SERVICES AND INSTITUTIONAL MANAGEMENT BY BRINGING THE LATEST COMPUTER TECHNOLOGY TO BEAR ON THE COLLECTION, ANALYSIS, AND REPORTING OF MANAGEMENT INFORMATION. TO THIS END, GRANT FUNDS HAVE BEEN USED TO SELECT AND PURCHASE A STUDENT INFORMATION SYSTEM (THE FIRST MODULE OF AN INTEGRATED MANAGEMENT INFORMATION SYSTEM) AND REQUIRED HARDWARE. THE CURRENT ACTIVITIES FUNDED BY THE GRANT ARE DIRECTED TO CONVERTING MANUAL SYSTEMS TO A FULLY INTEGRATED ELECTRONIC REGISTRATION, RECORDS, GRADING, ADMISSIONS, BILLING, AND FINANCIAL AID SYSTEM. WE EXPECT TO TEST THIS NEW STUDENT INFORMATION SYSTEM DURING THE COMING SUMMER.

THE 1989-90 FISCAL YEAR CONSTITUTES THE THIRD AND CRITICAL YEAR OF OUR THREE YEAR GRANT. I EMPHASIZE CRITICAL BECAUSE IT IS DURING THIS COMING YEAR THAT WE ARE SCHEDULED TO PROVIDE DIVISION AND DEPARTMENT CHAIRS, FACULTY ADVISORS, FACULTY, AND COUNSELORS ACCESS TO APPROPRIATE FILES IN THE STUDENT INFORMATION SYSTEM. THE GRANT WILL FUND ACTIVITIES TO DEVELOP COMMUNICATION LINKS BETWEEN USERS AND THE MAIN COMPUTER AND, MOST IMPORTANTLY, TRAIN PERSONNEL TO ACCESS AND USE THE INFORMATION FOR PLANNING, PROGRAM ASSESSMENT, AND STUDENT ADVISING. IT HAS BEEN OUR BELIEF FROM THE START OF THIS PROJECT THAT THE EFFECTIVENESS OF A MANAGEMENT INFORMATION SYSTEM IS DEPENDENT ON THE NUMBER OF PEOPLE WHO HAVE ACCESS TO THE SYSTEM AND KNOW HOW TO USE INFORMATION TO PLAN, ADMINISTER, AND ASSESS PROGRAMS AND ACTIVITIES IN THEIR AREAS OF RESPONSIBILITIES. IF WE ARE TO REALIZE THE FULL POTENTIAL OF THE MANAGEMENT INFORMATION SYSTEM WE NOW HAVE IN HAND AND IF WE ARE TO BASE OUR

MANAGEMENT DECISIONS AT ALL LEVELS ON TIMELY AND ACCURATE INFORMATION, THEN IT IS CRITICAL THAT OUR GRANT AWARD BE FULLY FUNDED AND CONTINUED INTO ITS THIRD YEAR.

THE UNIVERSITY OF HAWAII AT HILO IS BUT ONE EXAMPLE OF DEVELOPING INSTITUTIONS THAT ARE DIRECTING TITLE III FUNDS TOWARDS SIGNIFICANT INSTITUTIONAL IMPROVEMENT PROJECTS. THESE PROJECTS RANGE FROM THE IMPROVEMENT OF MANAGEMENT PRACTICES TO THE IMPROVEMENT OF ACADEMIC PROGRAMS, FROM THE DEVELOPMENT OF STUDENT SERVICES TO THE ENHANCEMENT OF TEACHING EFFECTIVENESS. TITLE III GRANTS STIMULATE AMONG FACULTY AND ADMINISTRATORS A SPIRIT OF CREATIVITY AND HEIGHTENED INTEREST IN THE SPECTRUM OF ACTIVITIES RELATED TO TEACHING AND LEARNING. THE TITLE III PROGRAM IS FULFILLING ITS PURPOSE. THE UNIVERSITY OF HAWAII AT HILO IS EVIDENCE OF THAT FULFILLMENT.

THUS, FOR THE CONTINUED STRENGTHENING OF DEVELOPING INSTITUTIONS OF HIGHER EDUCATION ACROSS THIS COUNTRY, I CALL UPON CONGRESS TO TAKE TWO MAJOR ACTIONS:

1. INSURE THAT BOTH COMMUNITY COLLEGES AND FOUR YEAR INSTITUTIONS CONTINUE TO RECEIVE FUNDING UNDER THE TITLE III PROGRAM TO SUPPORT GRANT ACTIVITIES ALREADY UNDERWAY.
2. APPROPRIATE SUFFICIENT FUNDS TO SUPPORT NEW GRANTS TO DEVELOPING INSTITUTIONS.

THANK YOU.

STATEMENT OF RICHARD E. MCDOWELL, PRESIDENT, UNIVERSITY OF PITTSBURGH AT BRADFORD

The Title III program has been invaluable in helping developing institutions to move into the main stream of higher education in the nation and to take large strides toward self-sufficiency. Because the program has been so essential in the development of the University of Pittsburgh at Bradford (UPB), I welcome this opportunity to submit written testimony on the benefits of Title III. I also want to urge your strong support for this program, with revisions which will make it more equitable to four-year colleges, in the coming decade.

The benefits of the Title III program can best be suggested by providing a brief overview of the history of UPB and then describing the region which it serves. This will indicate how critical Title III support has been to meeting the need for higher education in this large, rural area and to strengthening the academic and administrative capabilities of the college in serving this area.

The University of Pittsburgh at Bradford was established in 1963 as a two-year relocation campus. By the late seventies it became increasingly clear that the college had to redefine its mission if it was to survive and assist a very large and underserved region of Pennsylvania. Referrals from Pittsburgh began to decline while direct applications to UPB began to increase; several associate degree programs--particularly in petroleum technology and computer programming--began to fall off significantly; and there was increasing demand by adult students for baccalaureate programs which could be completed right in the area. The college began offering such degrees in the mid seventies under the auspices of the School of General Studies in Pittsburgh, and in 1979 the University approved UPB's request to set its own standards for degrees.

There was a major problem, however: The University did not have the funds to seed the development of UPB from a two-year to a four-year institution. Since becoming state related in the sixties, the University of Pittsburgh has received about twenty-eight percent of its operating funds from the Commonwealth. Unfortunately, support for higher education in Pennsylvania has lagged significantly behind that in the rest of the country. Data published by the Illinois State University Center for Higher Education, for example, indicates that in the decade prior to 1986-87, and adjusted for inflation, Pennsylvania's support actually declined 13% while the national average increased by 21%, led by states such as Massachusetts and New Jersey. In fact, Pennsylvania ranked dead last among the 50 states in terms of increased support for higher education. This highlights how critical Title III support has been to making UPB a viable baccalaureate college in a large rural area which has been very poorly served in the past.

An overview of the region that UPB serves will indicate how far it is behind the rest of the nation in higher education. While Pennsylvania has a good reputation for the number and quality of its colleges and universities, it actually falls in the lowest fifth among the states in terms of the percentage of the population having completed college, and only three other states have a lower percentage of those completing at least some college study. UPB's primary service region in northcentral Pennsylvania, in turn, falls significantly below state levels achievement and thus even further below the national average. In this six county region, nearly the size of Connecticut, the percentage of college graduates runs 32% to 57% below the state average and 43% to 64% below the national average. Higher levels of unemployment and lower levels of social services in this large rural area further retard the opportunities of its people to improve their lives and to contribute to the development of this upper Appalachian region.

Given the limited resources of the University of Pittsburgh and the great need for higher education opportunities in northcentral Pennsylvania, Title III provided essential support to help redress serious inequalities in the area. The gap continues to widen, however, because the college participation rate in UPB's service region remains about 12% below the state average and 16% below the national average. That is, only 38.7% of the region's young people go on to postsecondary education compared to 50.5% for the state and 54.2% for the nation. This points to the continued need for Title III support to developing colleges such as UPB.

It is for this reason that we hope that this Committee will continue to support the Title III program. We believe other institutions face similar problems. The Institutional Aid program has certainly been of tremendous assistance to UPB and to the people of this region in moving into the main stream of American life. Much remains to be done, however, to realize this dream.

As a four-year college we are, however, gravely concerned about the Higher Education Amendments of 1986, which created a very large set aside in the Title III program for community colleges. This legislation tripled the funds going to community colleges under Part A, the Strengthening Program, of Title III from 24% in 1986 to 73% in 1987. This massive reapportionment of funds has severely restricted the opportunities of four-year institutions to develop their academic and administrative capabilities.

Perhaps the nation should indeed make the development of community colleges a much higher priority than before. The legislation itself, however, provided no justification or explanation for such a dramatic shift of support away from baccalaureate colleges. The reasons for this reversal were certainly not self-evident. Thus, we feel very strongly that this decision should be reconsidered and the arguments for funding formulas be weighed carefully. We are very grateful that the appropriate authorizing bodies have indicated that they will revisit this issue.

UPB is now in the last year of its seven-year grant. The difference between the college in 1982, when it received its first Title III support, and today is dramatic. This assistance has enabled UPB to take significant steps toward offering varied baccalaureate programs to the people of this region. With no other college in Pennsylvania closer than nearly two hours from Bradford over rugged terrain, Title III has helped in a critical way in bringing higher education opportunities to an isolated rural area. This has been a real success story for the Title III, for UPB, and for the people of the region. For this we are very grateful.

Given the benefits Title III has produced for our college, and that it can produce for other institutions facing similar problems, we strongly urge that the program be continued. It has offered essential support to meet the increasing need for strong higher education programs to serve less advantaged portions of our population. That is a vital national interest, and its continued pursuit will benefit us all.

STATEMENT OF WILVERIA B. ATKINSON, PH.D., THE NATIONAL ASSOCIATION FOR EQUAL OPPORTUNITY IN HIGHER EDUCATION

The National Association for Equal Opportunity in Higher Education (NAFEO) is the organization of Presidents and Chancellors of the Historically and Other Predominantly Black Colleges and Universities (HPBCUs). The committee on which I serve functions to 1) monitor participatory opportunities in science and technology for member institutions, 2) provide forums in which scientists from our institutions engage in dialogue with relevant governmental and private agencies, and 3) advocate programs and processes that enhance the scientific and technological capabilities of our institutions. It is for the support of the National Institutes of Health programs designed to increase the number of under-represented minorities that are engaged in biomedical research that I beseech you today. As you know, only 17% of black college-bound students enter the HPBCUs, yet we graduate in excess of 50% of all black students earning a baccalaureate degree. This means that a significant percentage of our youth who go to majority colleges do not graduate. The programs I am going to describe not only aid in the retention of our black youth, but prepare them for advanced study in the biomedical sciences. Your actions can help us to significantly increase the number of minorities with the cognitive and psychomotor skills needed to become productive scientists.

The Minority Access to Research Careers (MARC) undergraduate program has exhibited tremendous success. In 1988, 81 percent of the MARC students who earned the B.S. degree successfully competed for and matriculated in graduate school. The program serves Native Americans, Black, Hispanic, and Native Hawaiian populations. Currently, 59 institutions have MARC programs. Students eligible to compete for a MARC Traineeship must be honor students at their respective institutions. They apply for the MARC honors program during the second semester of the sophomore year. If accepted, their participation begins the summer of the rising junior year. Minority students work diligently during their freshman and sophomore years in college to become eligible to compete for a MARC Traineeship. We respectfully request that you allow for the extension of the MARC honors program to the freshman year. This can be done by exempting the MARC Undergraduate Honors Program from the Trainee total previously set by the Congress for pre-doctoral traineeships. This exemption could be made in your appropriation language. Knowledge of the availability of a competitive honors program would motivate many minority high school students to excel. Institutions with MARC Programs have in place criteria with which to select scholarship recipients. Such criteria could easily be modified if required for the MARC program. As a direct result of the success of the MARC Undergraduate Honors Program, other federal agencies are initiating similar programs using MARC as a model. Such a program is the Research Careers for Minority Scholars (RCMS) of the National Science Foundation (NSF). Of special interest, a college can request support for honor students in high school and continue the students' support until they receive the B.S. degree. The NSF program does not target its honor students towards careers in biomedical research. Therefore, in order to attract minority students to prepare for careers in biomedical research, The MARC Undergraduate Honors Program should be available to minority students in their freshman year of college. Even with national success verified by the National_Research Council of the National Academy of Sciences, the Administration's budget request for the MARC Program is less than is required to maintain the program at its current level. A supplement of five million dollars to the Administration's budget request is therefore needed for the MARC program to maintain 59 on-going programs (3.5 million) and extend support of students, competitively, to the freshman year of college (1.5 million dollars).

The Minority Biomedical Research Support (MBRS) program currently provides support to 98 colleges and universities. The goal of the program is to address the under-representation of ethnic minorities involved in biomedical research by 1) improving the research environment at developing minority institutions, 2) providing research-grant support for faculty at underdeveloped minority institutions, and 3) stimulating student development through participation in funded biomedical research. The success of the MBRS program is well documented. Since its creation by Congress in 1971 and its first awards in 1972, 90 institutions without prior biomedical research capabilities now have such capabilities. The institution at which I work, Winston-Salem State University (WSSU), is an example of an MBRS success story. Prior to MBRS funding in 1972, no graduate of WSSU in its 80-year history had gone to medical school or to a graduate program in a basic medical science. Only one graduate had gone to dental school. Of our 73 MBRS graduates, 14 have graduate degrees and 5 are in graduate school, 25 have earned the M.D. degree and 8 are in medical school, 3 have earned the D.D.S. degree and 4 are in dental school, 1 earned the D.P.M. degree, and 18 are either working in health-related or education positions, or trying to get accepted for advanced study. (Four graduates with the M.D. degree and 1 graduate with the D.D.S. degree also earned graduate degrees.) Our success rate, which is typical of MBRS programs, is 83.5% for MBRS graduates going on to obtain advanced degrees. Although the MBRS program has documentable success, many approved applications remain unfunded. This is because of a history of inadequate budget requests for the program. A supplement of 5 million dollars is needed so that approved applications can be funded. This amount will also allow graduate student salaries to be increased from $5,640/yr to $8,000/yr.

The National Institutes of Health has an on-going program that involves minority high school students in biomedical research.

However, the program requires only that the student be involved in research for a minimum of 8 weeks. No structured program is required. The National Advisory Council for the MBRS program has approved a high school component for MBRS programs at minority institutions. The approved high school component would allow for continuing involvement of selected minority students with MBRS faculty and students. Mentorship coupled with research involvement would provide a stable mechanism of not only attracting but retaining minority students in the biomedical sciences.

MBRS Thematic Grants approved for 4 years will end after one year because of a lack of MBRS funds. Tuskeegee University's program had established the needed laboratory facilities and collaborations with other institutions when it was informed that funds would not be available after this June. Florida A & M University school of Pharmacy along with two other institutions are in the same situation. Thematic grants provide for an interdisciplinary approach to a biomedical problem. Due to the complex nature of most illnesses, such an approach is valuable and warrants support.

The Research Centers in Minority Institutions (RRCMI) Grants are located in our institutions with very high research potential. Currently, approved AIDS research projects will go unfunded unless additional funds become available. Due to the disproportionate numbers of minorities with AIDS when compared to the general population, AIDS research has special significance for our institutions.

In summary, we respectfully request that you

1) Exempt the MARC Undergraduate Honors Program from the total placed on NIH pre-doctoral trainees because the students are undergraduates;
2) Provide a supplement of 5 million dollars for the MARC program;
3) Support the MBRS programs with an increase of 8 million dollars for regular programs, the high school component, and the Thematic grants; and
4) Provide an additional 1 million dollars of the AIDS appropriation to the RCMI program.

The increased percentage of minorities in the total population has been nationally signaled. The projected increase has been identified by several different agents. In the interest of national survival, we must adequately provide for the training and inclusion of minorities. If we do not, America of the future may not be the "land of the free and the home of the brave".

STATEMENT OF ELLIOT RICHARDSON, CHAIRMAN OF THE BOARD, READING IS FUNDAMENTAL, INC.

Reading Is Fundamental (RIF), appreciates the opportunity to present recommendations on the Inexpensive Book Distribution Program — (P.L. 100-297, Chapter 2, Part B, National Programs Priority Funding, Sec. 1561(b)(2) and Sec. 1563). The Book Program, operated by RIF, responds to the vital need: to prevent illiteracy, by working at the level where literacy begins: with children.

The current number of functionally illiterate adults is conservatively placed at more than 21 million. They pay a heavy price. So does the taxpayer; so does American industry. We are told that each year: inadequate skills among adults cost American business about $25 billion a year; some 700,000 high school graduates who cannot read well enough to understand their own diplomas; and about 1 million never graduate at all.

At this rate, by the year 2000 another 18,700,000 young adults will be in their communities ill-equipped to support themselves. The social and economic costs will be prohibitive.

There is an affordable alternative. We can motivate our children to read, to learn, and to grow into literate, thinking adults. That is what RIF, through the Book Program, does for 1 in 22 American youngsters between the ages of three and seventeen. It gets them to want to read, to read often and to read well.

RIF uses books as the centerpiece of activities that encourage reading. And it lets children choose books they want and will read, to take home and keep, at no cost to them or their families. RIF's nationwide network of grassroots projects, staffed by volunteers, credit RIF's achievements in upgrading reading abilities and desire to learn. These children will not grow up illiterate.

RIF RECOMMENDS FY 1990 APPROPRIATION OF $10 MILLION

The Department of Education has requested FY'90 funding of $8.684 million. RIF respectfully recommends an appropriation of $10 million for the Inexpensive Book Distribution Program, a modest increase, that would maintain current services; help stem the erosion of the program; meet, in small part, the demand for its services; and is, we believe justified for the following reasons:

o Inflation has far outstripped appropriations, especially in the program's major cost, books for children. The result since 1980 has been a significant decrease in the number of children served by this highly successful program. Between 1980 and 1989 the general inflation rate, according to the Congressional Budget Office, was 41.1%.

Of even greater consequence to the Book Program has been the rising cost of books. For example, in 1980 the popular Goodnight Moon cost $1.50. Today it costs $3.50. RIF has negotiated major nationwide discounts with 347 book suppliers. Nonetheless, since 1980, the overall cost of children's books has increased by about 100%, a rate far greater than that for general inflation. However, funding for the Book Program in the same period increased by only 29%.

The disparity between costs and available funds has led inevitably to a major decrease in the number of children served.

- Today the Book Program serves 662,000 fewer children than it did in 1980. In 1980 RIF brought 11 million books to 3 million children. Today it brings only 7.5 million books (3.5 million fewer than in 1980) to 2,338,000 children.
- Meanwhile, demand for the program has accelerated. The media and formal, government-funded studies have lauded RIF's method and achievements. The public has responded. Last year alone, for lack of funds, RIF had to discourage over 1,500 groups from even applying for book monies.
- Important recent research on achieving literacy emphasizes the importance of books in the home, parental involvement, and reading motivation. RIF is the only nationwide program combining all these elements while letting children choose and keep books of their own.

Funding at the Education Department suggested level of $8.684 million would result in further erosion, a loss of services to at least another 165,000 children.

An appropriation of $10 million would permit RIF to restore some of the loss since 1980 by allowing it to reach nearly 2.5 million children with more than 7.9 million books.

THE BOOK PROGRAM FILLS A GAP, MEETS A CRITICAL NEED

Nearly every American child learns the basics of how to read in elementary school. But somewhere between then and adulthood, an alarming number fail to perfect or maintain the skill.

The lack of adequate skills has been so well documented that we cite only two statistics pointing to the ominous implications for the country in an increasingly competitive, high-tech world: A Department of Education study predicted that only 5% of high school graduates will possess the reading skills needed for professional and technical work; and a Business Roundtable survey noted that as many as 60% of high school graduates are not prepared even for entry-level jobs.

The question as to how this can happen in America has spawned many theories. What we can say with certainty, however, is that children who early on come to love to read, who read often, who possess, treasure and use books, and who are motivated to learn, are not destined to become a part of tomorrow's grim literacy statistics. We can count on them to grow into literate, imaginative, thinking adults. Unfortunately too many children have little or no access to books, other than textbooks, and little incentive to read.

We have only one chance to prevent illiteracy: with the children. Every child who grows up with inadequate skills represents a missed opportunity. As it stands now, we are missing too many.

A TRAIL BLAZING PROGRAM TO CREATE READERS

When RIF was founded in 1966, its approach of providing children with real books (not just basal texts) and involving parents in their children's education was novel. But Congress recognized the method's inherent sense long before the recent spate of studies gave official credence to the premise that children with positive experiences with books and reading grow into fluent, able readers and literate adults.

In 1976 Congress created the Inexpensive Book Distribution Program making RIF's approach a trail blazing part of the national education policy. By providing funds to help communities bring books to children, Congress gave the program the boost it needed to take root throughout the country. Today RIF and the Book Program, reach 2.3 million children in every State, Washington, D.C., and the U.S. offshore possessions.

In establishing the Book Program, the Congress wisely left intact the unfettered practicality that has been RIF's hallmark. The result is a genuinely grassroots, non-bureaucratic, hands-on program that gets children to read. It does so with the help of 96,000 volunteers from all walks of life and economic levels. They select the children to serve, the books to place before them and entice them to read with creative activities that express the pleasures and importance of the written word.

IBDP SUCCEEDS WITH DIVERSE GROUPS, IN A VARIETY OF SETTINGS

Each year brings more reports and studies that further justify the confidence of Congress in the Book Program. The evidence is overwhelming that the combination of books in the home, motivation to read, and parental involvement is a formula for literacy.

In past years we have quoted "First Lessons," "What Works," "Becoming a Nation of Readers," and other important studies, which all emphasize the relationship between reading achievement and frequency of reading, motivation, parent involvement, ready access to books, and books in the home.

RIF is bringing books and reading into the homes of children of diverse racial, ethnic, and economic backgrounds, in the inner cities, in rural areas, and to many who are often left out of society's mainstream. Says a Migrant Home Study Supervisor from California: "Never before in my ten years with Migrant Education have I seen such a welcome, well-needed and well-deserved motivator like RIF books...the best thing I've ever seen for our students."

And while many programs are, necessarily, limited to school settings, RIF can reach children wherever they are. Through 3,390 local projects serving more than 11,000 separate locations, RIF reaches children in schools, libraries, housing projects, migrant labor camps, homeless shelters, hospitals, juvenile detention centers, Indian reservations, and other places.

At the State Correctional Institution in Graterford, Pennsylvania, for example, a church group and prison inmates have joined forces to bring RIF to the children of the inmates, to the benefit of both the incarcerated parents and their children.

Whatever the setting or their background, children respond to RIF in remarkably similiar ways:

- increased reading and use of libraries;
- improved reading scores;
- better attitudes toward reading and education;
- greater reading involvement with their parents.

Typical are the reactions of children in two Iowa cities: in Latimer where the Friends of the Library note that library circulation is up by 15%, and in Johnston where the Chapter One Reading Teacher reports that reading scores have risen.

Perhaps one of RIF's most important achievements is its ability to draw parents into their children's education. More than 37% of RIF's volunteers are parents of the children served. Many had never before found a comfortable way to be a part of their children's education.

A LOW COST, COST-EFFECTIVE WAY TO GET CHILDREN TO READ

RIF projects are staffed by unpaid volunteers. RIF projects receive Federal funds only for the purchase of books — none for administrative or other program costs. And they must provide private funds for their local matching share.

As a result, last year the Book Program was getting children to read at a cost to the government of only $3.34 per child.

The Book Program costs the taxpayer little, and it serves as the foundation upon which other reading services are built at no cost to the government. It has drawn private sector support to provide such things as reading programs for "at risk" families, guidance for parents, college scholarships, reading contests, matching book funds, and a media campaign to promote reading.

Last year RIF and its projects garnered private funds, goods, and services for their reading programs amounting to nearly $3.00 for every $1.00 appropriated for the Book Program. The additional funds and services are there only because the Book Program is.

This is a remarkable return. Yet a stark fact remains: at present funding levels, this highly effective program can still reach less than 5% of those eligible for its services.

A SMALL INVESTMENT TOWARD A LITERATE AMERICA

Our nation has needs and expectations of the upcoming generation. First and foremost is that they will be able to read.

The Book Program offers a proven and affordable way to help meet that need. Its rewards are disproportionately high in relation to its cost. Although a tiny fraction of the Federal budget, it offers a major means toward creating a literate society.

BECAUSE:

- There has been a steady erosion of this proven program since 1980 as inflation outpaced appropriations;
- The need and demand for the program far exceed its resources;
- Literacy begins with children, and too many remain unreached;

AND BECAUSE THE BOOK PROGRAM:

- Succeeds in getting children to read;
- Is a low-cost way to combat the decline in literacy;
- Offers communities a practical, effective, and appealing means to get their children to read;

Reading Is Fundamental respectfully requests the Congress to appropriate $10 million for the Inexpensive Book Distribution Program.

STATEMENT OF STEPHEN A. JANGER, PRESIDENT, CLOSE UP FOUNDATION

Mr. Chairman, Members of this Subcommittee, my name is Stephen A. Janger and I am president of the Close Up Foundation, a nonprofit, nonpartisan organization committed to stimulating responsible participation in the democratic process through educational programs in government and citizenship. I have the distinct privilege, once again, of submitting this testimony in support of the Allen J. Ellender Fellowship Program. As you know, these fellowships help to assure the participation of economically disadvantaged students and their teachers in the Close Up Washington Program. The Ellender Fellowships are augmented by private sector support, creating a strong multiplier effect of participation and expanding our outreach even more to underserved constituencies.

THE MISSION

Since 1972 when the Ellender Fellowships were established, I have had the the opportunity to share with Congress the programmatic anecdotes and exciting educational initiatives at Close Up. As I enter my 20th year with Close Up, I can't help but pause to offer thanks to so many who have made the mission of this organization possible. Through this help, Close Up has been able to reach out to the student, the teacher, the older American, reinforcing their crucial role of participation in this pluralistic society. A short month ago, we were very proud to have conducted our 250,000th participant through our Washington Program. For an organization that started its first Washington week with 25 participants, it was a proud and thankful time. This year alone, some 27,000 participants will come through our Washington Program.

In 1970, I, and the others who helped establish the Foundation, pledged that the Close Up Washington experience would be accessible to students and educators of all backgrounds, regardless of geographic location, academic ability, physical handicaps, or economic circumstances. Mr. Chairman, I am proud that we have maintained that pledge. Even so, we continue to strive to meet the challenges of working with greater numbers of America's diverse and often underserved constituencies.

Let me take a moment to give you an idea of the diversity of our student participants. We involve students and teachers from all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, and the United States territories. From isolated fishing villages in Alaska, to the heart of our inner cities, to remote rural regions, to island communities, and to schools located on reservations, Close Up has reached out with educational opportunities to every corner of this great nation.

Close Up has also taken several steps to ensure that students with special needs can be mainstreamed into the Washington Program:

* Purchased simultaneous interpretation devices and translated several of our publications into Spanish to accommodate students with limited English proficiency;
* Offered fellowships to severely handicapped students and their personal aides from home; in addition we provide health technicians familiar with the Close Up Program and Washington to provide additional assistance;
* Provided special help and interpreters for thousands of moderately physically challenged students, and those who are hearing or visually impaired.

We are particularly concerned with reaching the at-risk student, and our efforts have clearly yielded remarkable results. A San Francisco woman recently shared a heartening story with us:

> Alex had recently been having trouble in school. His grades had fallen, he had lost interest in sports, he was frequently truant and ultimately was transferred from the regular high school to an alternative school....When Alex returned home from Close Up his grades improved markedly, he was no longer truant and his friends changed. By springtime, he was permitted to return to the local high school and graduated with his class in June....I'm not sure whether "Close Up" can be credited entirely with the turn-around, but it certainly was a major factor in getting Alex's life back on track.

There are similar stories in every Close Up community in the country and they never fail to inspire our efforts.

Initially, Close Up targeted high school students and their teachers for its Washington Program. Over the years, however, we have identified other groups of individuals who would benefit substantially from civic education programs and specially designed curricula for their participation. Citizenship education has most often been viewed as a rite of passage for the young. It is an important rite of passage for the young, but the story must not end there. Civic learning and involvement are lifelong challenges and responsibilities. To help underscore this point, five years ago, we initiated our Program for Older Americans.

Since then more than 2,000 senior citizens have had the opportunity to examine firsthand how our government functions and they have returned home with a renewed sense of civic efficacy. These individuals take our message of personal involvement seriously and have undertaken a wide variety of activities in their communities.

Traditionally, education activities are segregated by age group. Close Up is now breaking this barrier by establishing intergenerational programs, both here in Washington and throughout the country. As the different age groups trade views, everyone gains a unique understanding of another generation's perspective. The result is an enriched learning experience for all. In order to encourage more intergenerational activities we have published and are distributing Building Bridges to Citizenship, a resource book which describes how to conduct intergenerational programs. We anticipate that thousands of individuals will directly benefit from the initiatives that will result from these efforts.

In 1988, we began a Program for New Americans in an effort to help schools deal with the estimated 2.7 million immigrant children who now constitute six percent of the nation's public school enrollments. The program is designed for tenth- and eleventh-grade students who have recently moved to the United States. This program helps these new Americans focus their futures in a new direction -- to see themselves as part of their new homeland. The three-part program begins with civic learning activities in local communities; extends to a weeklong program in Washington, D.C.; and culminates in a service project that is implemented in the home community. Last year, 120 new Americans participated in a unique pilot effort from three areas; this year, we will bring nearly 400 of these special students from 19 communities throughout the country.

To date, support for the Program for Older Americans and the Program for New Americans has come solely from the corporate and philanthropic sectors. Last year, however, Congress authorized these two new programs to be included in the Ellender Fellowship Program. Funding appropriated last year will be used during our upcoming 1989/90 program year beginning this fall. This new congressional support has already helped open fruitful discussions with the private sector about establishing effective partnerships in years to come.

REACHING OUT

Mr. Chairman, the majority of our programs do not involve any federal funds, but each is essential to our commitment to involve as many individuals as possible in citizenship education activities. Our weekly public affairs television programs are aired over the C-SPAN cable network which reaches more than 40 million households, and the tapes are made available to high school teachers throughout the country for use in the classroom.

Our publications, many of which I am pleased to say have won awards, are now available to schools across the country beyond those that participate in Close Up. And Close Up local programs, held onsite in 150 communities throughout the nation, involve nearly 50,000 students and teachers and bring an exciting hands-on dimension to local, state, and regional issues.

Our Citizen Bee competition, initiated four years ago, helps stimulate interest in learning more about history, geography, economics, current events, American culture, and government. During this current year, some 36,000 students from 2,500 high schools in 29 states have participated. We anticipate 11 additional states will take part next year; and by the 1990/91 academic year, we expect that all 50 states will be taking part.

Two years ago, in response to longstanding requests from educators to find new ways of reaching students before the high school years, Close Up initiated a supplemental civic education activity, the Civic Achievement Award Program (CAAP) for students in grades five through eight. Students work cooperatively to 1) master basic information on history, economics, geography, American culture, and government; 2) develop library and research skills; and 3) participate in a voluntary community service project. The National Association of Elementary School Principals has been working in a partnership with the Close Up Foundation that has enabled us to reach more than 24,000 young people during the second year of pilot implementation.

A LASTING IMPRESSION

Close Up's Washington Program is only one week long, but its impact does not begin or end with the time students spend in Washington. Since its inception, Close Up has witnessed its participants generating countless volunteer hours in their communities. In fact, volunteerism has been an enduring theme in Close Up. Students, teachers, and parents spend time outside the classroom, not only to prepare for the week in Washington, but also to identify community sponsors. Thousands of speakers address our students every year on a volunteer basis. Senior citizen participants return from Washington, D.C., and help establish collaborative programs with our high school students; and our high school students have begun to work with elementary and middle school youngsters.

Many of our participants have become active in political campaigns, voter registration drives, community service activities, and indeed, in congressional offices and membership and trade associations here in Washington.

Time and time again I meet young people -- and, by now, some are not so young -- who have an unmistakable look of recognition when they hear the words "Close Up". It is always gratifying to learn about the lasting educational impact of the Close Up experience. Frequently, we get calls from alumni who work on Capitol Hill or in the Washington metropolitan area and tell us, as one recently did:

> You're the reason I'm here!...You made me realize that I could be part of the process....If I can ever do something -- speak to the kids -- whatever -- let me know!

Former participants often inquire about their program instructors and tell us what positive role models they were.

> There was one thing that made my trip the truly life-transforming experience that it was, and that was my program instructor....I have never been so motivated and, quite frankly, moved than by what she taught us.

Teachers also tell us that Close Up continues to be the most important in-service opportunity available to them. They report that the information and insights they acquire through workshops and onsite study visits here in Washington are taken back and used in the classroom. Teachers also report that Close Up is one of the best antidotes to professional burnout. They return to their schools inspired, with a renewed sense of the importance of their work.

Studies and reports about education seem to agree on one thing -- the lack of civic literacy among students and young adults, and, indeed, the entire population, threatens all democratic institutions. All of us concerned with this issue must continue our work with a renewed sense of urgency and purpose.

REQUEST FOR FISCAL YEAR 1990

Mr. Chairman, our Washington Program continues to grow because students, educators, civic leaders, public and corporate officials tell us that it works well. In addition to creating substantive knowledge, it acts as a connector for our participants to America and to our system of government. At its core is a cross section of participants from all backgrounds. The Ellender Fellowships are key to this healthy cross section of participation. They assist us in reaching out to neglected constituencies and help to establish local and national funding partnerships that endure. We work hard to maximize their effectiveness.

We are requesting a very limited increase in funding for the major part of the Ellender Fellowships (now referred to as Part I). Specifically, we respectfully request an FY90 appropriation of $3.4 million (an increase of $400,000) for use during our 1990/91 academic year. This increase will permit Close Up to continue to reach out to more corners of America, to more disadvantaged young people and their teachers. It will help counter slight rises in cost and create, as well, additional partnerships with the private sector.

As I mentioned earlier, we have not yet had the opportunity to use the $494,000 appropriated last year for Part II of the Ellender Fellowships for needy senior citizens and recent immigrants (The Close Up Program for Older Americans, The Close Up Program for New Americans). Our experience with these two programs indicates potential for a strong partnership and multiplier effect. We are excited about local community support and national sponsorship opportunities. For this Part II portion of the Ellender Fellowships, we are respectfully requesting $1 million (an increase of $500,000). This level of funding, along with effective partnerships, should allow us to bring as many as 600 economically disadvantaged senior citizens and as many as 1800 new American students from up to 45 communities through our Washington Program. The community forums for these returning participants will multiply the experience significantly.

In making this request Close Up makes a commitment to encourage even greater participation in the democratic process in the belief that informed and active citizens are essential to a responsive government. The Foundation also makes a commitment to engage additional sponsors from the private and philanthropic sector, large and small, who share our vision and our urgent concern for the civic education of this nation's citizens.

Mr. Chairman, all of us at Close Up know only too well that our request to modestly expand these federal seed monies comes at a time of budgetary constraints. We hope, however, that you and other members of this Subcommittee will consider our record of accomplishment, the widespread and growing enthusiasm for our work, the recognized need for civic education assistance for so many of our at-risk and often neglected constituencies, and our unwavering commitment to multiply significantly these important resources. I thank you for the opportunity to present this testimony, for your strong support in years past, and for your consideration of this current request. I know that the thousands of teachers, students, senior citizens, and new Americans who will have the opportunity to learn more about their government would also wish me to express their deep gratitude.

Again, thank you. I would be pleased to answer any questions that you or other members of the Subcommittee may have.

STATEMENT OF GERALD MORRIS, DEPUTY DIRECTOR OF LEGISLATION, AMERICAN FEDERATION OF TEACHERS, AFL-CIO

Mr. Chairman and Members of the Subcommittee: On behalf of the American Federation of Teachers, AFL-CIO, I would like to express our appreciation for this opportunity to testify on education appropriations for Fiscal Year 1990. The A.F.T. is very appreciative of the continuing efforts made by the Chairman and Members of the Subcommittee to adequately fund federal education programs. Over the last decade, the federal contribution to the support of education has seriously eroded, when looked at in constant dollars. Some programs, particularly those that are less well known, but nonetheless important, have absorbed severe cuts in funding. This has not occurred, however, without the strong opposition of this Subcommittee. Indeed, the general pattern has been one of this Subcommittee fighting to hold the line in real dollars or to ratchet up the proposals of the White House or the Senate. We are grateful for your leadership and support for education.

The Administration's FY'1990 budget proposals for education are clearly inadequate. Many of us in the education community expected our "education president" to come forward with a far more significant proposal for investment in education. Instead, what the Administration has proposed is modest additional funding for a small collection of programs, mostly unauthorized, which would apparently be offset by very substantial cuts in many of the remaining, time-tested educational programs. If one were to assume that education programs in the so-called "black box" were truly subject to an outlay freeze, some of the largest federal education programs would be cut by nearly fifty percent. This is a proposal for educational cannibalism, not for educational progress. The A.F.T. hopes you will reject the Administration's proposals and continue your good work to strengthen the base of the established and demonstrably effective federal education programs.

The A.F.T. shares the view of many of our nation's political, business and cultural leaders that education and early childhood programs must be among the highest priorities of Congress -- and that this level of priority must be expressed by a corresponding commitment of federal resources. Former Presidents Gerald Ford and Jimmy Carter recognized in The American Agenda that poverty among the nation's children has increased alarmingly and that we must add substantially to our investment in education and early childhood programs. The Committee for Economic Development has similarly called for a large increase in federal funding for early childhood and education programs. And, the Council on Competitiveness, recognizing the importance of education for strengthening our economy, has called for greater funding for early childhood programs and education for the disadvantaged at the elementary, secondary, and higher education levels. The Committee for a Responsible Budget found, in examining the attitudes of the public, that education, along with environmental programs, is a "sacred cow" in the federal budget. Thus, there is a widespread desire and an expectation that the federal government will provide increased resources for education and early childhood programs. Undoubtedly, the public understands that preparing disadvantaged children and youth for productive lives is even more important as we foresee an aging of the general population, a shortage of skilled workers, and when we recognize that one dollar invested now will eventually save many more dollars in social services.

The A.F.T. would like to suggest as a first priority for education appropriations an inflation adjustment for all education programs. Such an adjustment is necessary to maintain the purchasing power, or level of service, of these programs. It is also necessary to help maintain the broad base of services that contribute to the success of the principal federal education programs. From the A.F.T.'s viewpoint the federal role in identifying national priorities, in providing services to special populations, in underwriting a national research and data collection effort, and in contributing to the overall effectiveness of the nation's educational system, helps provide a continuous ladder for individual opportunity and means to improve the productivity of our economy. It is necessary that each rung on that ladder be securely maintained.

Beyond an inflation adjustment for all education programs, the A.F.T. would suggest to the Subcommittee significant funding increases in a number of areas. At the elementary - secondary level of education, Chapter One is the backbone of the federal effort to assist disadvantaged students. It is a program that is widely regarded as successful and well targeted. At the present time Chapter One has funds to serve barely more than one-half of eligible students. It should receive a substantial increase in funding, enough to go well beyond full funding of Concentration Grants. A.F.T. believes that Even Start and Secondary Basic Skills should also be funded at a very high level. Educators know that, as successful as Chapter One is, it can be even more successful by starting earlier, involving parents more thoroughly, and by continuing like services at the secondary level.

The Education of the Handicapped, State and Local Grant Program, should also receive a considerable increase in funds. The federal effort is still well below the earlier level of twelve percent of the national average per pupil expenditure and no where near the federal commitment of a forty percent level. Funding is particularly important in this area, as states move increasingly to provide service to children from three to five years of age.

Magnet Schools have become very effective in reducing minority group isolation, in increasing parental choice, and in promoting academic excellence. This success is evident in the widespread desire to significantly expand the magnet schools program. Vocational Education is in the process of reauthorization, during this and the next session of Congress. There is great support for improvements in the vocational education program to better link it with other education and training activities and to better target the program on special populations. Impact Aid remains a very important program for easing the fiscal burdens imposed by federal lands situated within school districts. A.F.T. believes that each of these programs should be accorded some priority in funding.

At the higher education level, Pell Grants remain the fundamental and most essential program for affording educational opportunity to disadvantaged students. Unfortunately, the purchasing power of Pell Grants has eroded over the last decade, and they no longer provide the foundation, often added to by other forms of student assistance, which they once did. The A.F.T. is particularly supportive of student aid, such as Pell Grants, for part-time students. The typical entering college student is no longer eighteen years old and from a relatively affluent family -- if indeed that was the case at any time in many years. Rather, many students are returning students, often with dependents and other time and money consuming responsibilities. A.F.T. urges the subcommittee to approve a significant increase in Pell Grant funds.

The Christa McAuliffe Fellowship Program is a model program for providing recognition and creative opportunity to outstanding teachers. These are commodities which are dear, but often in short supply, among teachers. The Paul Douglas Scholarships provide an incentive for attracting some of the best young students into the field of teaching. Special Assistance for the Virgin Islands recognizes the special responsibility of the United States for assisting education in the islands. Each of these programs is deserving of strong support.

The A.F.T. urges the committee to consider a significant investment in educational research and data collection. Given the critical problems facing schools, and their awesome responsibility, these activities have taken on an even greater value. Such activities can be of great value to the education reform movement, which is attempting to revitalize public education throughout the country.

Finally, I would like to call the Subcommittee's attention to several new provisions in the Nurse Education Act. The programs covered by this act were revised and expanded in the last Congress, in recognition of the nurse shortage problem. Previously the federal effort in the area of nurse education was confined almost exclusively to post-graduate training. Of course, the nurse shortage is most critical at the undergraduate level. The new law provides many opportunities for career ladders, for in-service training, and for attracting and educating students from a disadvantaged background. A.F.T. urges the Subcommittee to consider meaningful investments in Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds and Scholarships for Undergraduate Education of Professional Nurses.

Mr. Chairman and Members of the Subcommittee, the American Federation of Teachers again thanks you for your continuing support of education and for this opportunity to testify. A.F.T. looks forward to continuing its work with you to improve and strengthen educational opportunity for all Americans.

STATEMENT OF THE UNITED STATES CATHOLIC CONFERENCE

In *Aguilar* v. *Felton* (1985), the Supreme Court ruled that public school Chapter 1 teachers could no longer provide services in a classroom within church-affiliated schools. The ruling affected about 200,000 disadvantaged private school students and the LEAs who provided their services.[1] These LEAs had to find about 9,000 suitable off-site classrooms, and they could not. About 35% of the affected Chapter 1 students have lost their services.[2]

In its reauthorization of the Chapter 1 program, Congress provided new "capital expense" funds to help LEAs obtain the necessary facilities and restore Chapter 1 services. It authorized appropriations of $30 million for "capital expenses" in FY'88, $40 million for FY'89 and such sums as may be necessary for FY 1990 through '93.

So far, Congress has appropriated $20 million for FY'89 for Chapter 1 "capital expenses." This $20 million only begins to put the program back on track for private school students. At best, it can restore services to only about 20,000 of the 75,000 students the LEAs are not serving. And, because of the way in which these funds will be distributed among the LEAs, Congress will be fortunate if services can be restored to so many. Many districts will find their share of the $20 million too small to make the necessary capital purchases.

That means the FY'90 appropriation for capital funds must restore services to the remaining 40,000 to 60,000 students, at a cost of from $40 million to $60 million for the first year. In addition, a portion of the FY'90 appropriation must be allocated to sustain the facilities obtained with FY'89 funds. Based on our survey, we expect these annual costs to equal about 60% of the initial capital outlay--$12 million. We believe our testimony demonstrates the urgent need for an annual appropriation beginning with $40 million in FY 1990.

As of 1987-88:

- more than 35 percent of the private school students who received services in 1984–85 have lost them;
- only 9 states, the District of Columbia and Puerto Rico had restored some portion of Chapter 1 services to most of their students by the end of last year;
- the average loss in those states that failed to restore services is 40 percent;
- and, ominously, two-thirds of the losing states lost more students in 1987–88. These states are losing ground.[3]

Our own survey shows similar losses, with the greatest losses among students attending rural schools, integrated schools, and for minority students in the largest cities.[4]

Losing Ground: The Number of Students Losing Services Is Increasing

Immediately after *Aguilar*, 1985–86, 60,000 students received a half year of services and 60,000 others lost all services. In total, services worth about $100 million were lost to the equivalent of 90,000 students. In addition the 60,000 to whom services were restored typically received fewer services–delivered in larger classes, for shorter periods, meeting fewer times per week, receiving less reading and math–than their public school peers. A Department of Education sponsored study found that, in that year, the number of private school students assisted in reading dropped 37 percent; in math, 43 percent; and in language arts, 58 percent, while public school participation levels increased in each area.[5]

In 1986–87, in net, a few more students lost services. While some students who lost services the previous year regained them, about 60,000 students who had not been affected in the first year following *Aguilar* were brought under the off-site rules. Between 60,000 and 80,000 private school participants received no Chapter 1 help. These lost services were worth $70 million to $90 million.

In 1987–88, the data are incomplete[6]. Eleven SEAs report they have restored services to pre-*Aguilar* levels, but 33 others report that they are 40% short of that benchmark. *Of these 33, 22 states served fewer students than the year before. They are losing ground.* Altogether, 33 states report that they are not reaching 50,000 to 65,000 students. Assuming, based on their past record, the 8 non-reporting states failed to provide services to about 10,000 more students, then a total of 65,000 to 75,000 students remain without services in 1987-88. The lost services are worth $65 million to $80 million.

Altogether, 80 percent of the states have failed to restore Chapter 1 services to a an average of 40 percent of their private school students. In half the states, the loses are increasing. Each year since **Aguilar**, *60,000 and 75,000 private school students have not been given their services. And many of those counted as full participants actually received significantly truncated services. Congress has paid approximately $300 million for these lost services.*

These losses are going to continue and, in many states, to grow because too many LEAs lack cost-effective facilities for delivering services. Many approaches now impose punishing costs on participating private school students, particularly loss of class time for travel.

LEAs typically adopted one of four approaches for delivering Chapter 1 services:

- They asked the students to walk to a nearby public school or neutral site.
- They bussed students to more distant Chapter 1 centers.
- Or they used a van or mobile classroom to bring the teacher to the students, parking on a site close to the private school.
- Some are experimenting with computer-based instruction at the private school.

In 1986–87, about 29 percent of the private school were reached in vans or mobile units; about 53 percent at public schools or neutral sites; and about 17 percent through computers.

Some of these solutions were problematic. Walking or riding a distance forced many of the youngest children to drop from the program for safety reasons. Travel was especially difficult in bad weather and ate up valuable instruction time. In our survey, we found the average student being bussed to a neutral site spent 52 minutes of class time per week commuting, and received only 100 minutes of Chapter 1 instruction. If LEAs brought the teacher to the school in a van or mobile unit, commutation time was only 21 minutes per week. Where classes remained inside the private school–as for example computer instruction–it took only 10 minutes per week to move to the Chapter 1 room.

Costs of Off–Site Services

We have developed estimates of the costs of restoring Chapter 1 services so far, and the expected future costs, based on surveys of costs experienced by a number of LEAs across the country and on an analysis of the ways LEAs are now providing services.

Table 1: Chapter 1 Services for Private School Students After Aguilar, Location of Service[7]

	1984-85		1986-87		Change
Number of Students Served	200,000		125,000		-75,000
Location					
Inside Private School	180,000		25,000		
In nonsectarian schools				3,500	
By computer				21,500	
Off-Private School Site	20,000		100,000	80,000	
In Public School		13,000		27,000	14,000
In Vans and Mobiles		5,000		36,000	31,000
In Neutral Sites		2,000		37,000	35,000

Neutral Sites and Public Schools: About half the students using off-site facilities at a neutral site or public school had to be transported, at an average cost of $500 per student. Those not bussed generally required an aide as a chaperone, at about $350 per student.

The transit costs for 49,000 students was about $21 million, and these costs are recurring. About two-thirds of these students used neutral site, which normally had to be leased, furnished, and maintained, with costs averaging $350 per student. Thus site preparation so far has cost about $12.25 million for the needs of 35,000 students.

Vans and Mobile Classrooms: By far the most successful way of restoring services, and the most expensive, has been to bring the Chapter 1 classroom to the students by using a van (self-propelled) or a mobile classroom (portable, much like a mobile home.) Costs ranged widely, from a low of $250 per pupil (Denver) to a high of $3,500 each (New York.) Assuming Los Angeles is average at $1,000 per student the first year and $650 thereafter, it has cost about $16 million to provide services to about 16,000 students in vans for the first year, and $10 million per year thereafter. Portable classrooms were less expensive, with first year costs of $625 per student and $325 thereafter in L.A.. Again based on the Los Angeles experience, it It cost $9.3 million to serve the other 15,000 students in portable classrooms the first year and $5 million each year thereafter.

Computers: Public systems report they are serving about 20,000 private school students through the use of computers at the private school site. The private schools donate the computer room to the program, thus saving the program about $13 million the first year, and about $7 million thereafter. Preparation of the room--furniture, electrical, communications, security--has cost between $5,000 and $50,000 per room. Assuming costs average $7,500 for site preparation, the installation of computers cost about $7.5 million in the 1,000 classrooms where they are in use. In addition, under Department rulings, computers require some regular contact with a teacher, in a van or off-site facility, meeting about once a week. Because in the computer-based program, the students spends much less time off site, the costs of the off-site facility per student are lower, about $250 each, or $5 million for the 21,000 students now served by computers.

[Note that the Department of Education does not regard the acquisition of computers as a "capital expense"; they must be purchased from instructional funds The cost of the computers themselves appear to be similar to the cost of a full-time Chapter 1 teacher.]

Capital Costs of Restoring Services to Those Remaining Without Them

Last year about 75,000 students were still without Chapter 1 services. From our surveys we conclude that, in general, these students are more difficult to reach. The easy solutions were explored and did not work for these students. The LEAs needed to obtain vans or mobile units to restore services to most of them. If we assume that half the LEAs choose vans and half mobile units. then the first year costs should average about $800 per pupil for capital costs, and each additional year should average about $500 per pupil. Restoring services to them would cost $60 million for the first year.

In the near future, LEAs will have to find new approaches to substitute for methods of restoring services that are now failing. Off-site services which require a commute of 40 minutes or more per week during school hours are most likely to fail. We assume that one half of those now using public schools or neutral sites, 25,000 students, will have to be served in vans or mobile units in the near future, at an additional cost of $20 million the first year.

Each approach requiring a major capital investment will have continuing capital costs. The experience of most LEAs in our survey is that costs associated with transportation remain approximately stable, and costs associated with vans, site, preparation and the like, in succeeding years equal about 60% of the initial year costs.

Request Full Appropriation of the Authorized Capital Funds

Using conservative cost assumptions, it will cost $60 million more to restore services to all who lost them. It will cost an additional $20 million to convert impractical, inadequate off-site facilities to vans, to prevent further erosion of the program. So far LEAs have spent about $70 million in capital funds of their own, to restore services to 105,000 now receiving them off-site, and it costs another $42 million per year to support these facilities. The total capital funds necessary to restore services after *Aguilar*, **for the first year**, is about $150 million (including amounts already spent.) These solutions will carry capital costs in the second and succeeding year in the area of $100 million.

The appropriation of the full authorization, $40 million–and more–is needed. While these are considerable sums, they are small in relation to the problem. Congress has appropriated over $300 million for services that have been lost to these students, and each year $75 million more is lost. So a small expenditure will have a big payoff. But the real loss is the impact the failure to deliver these services may have on the future of these children.

[1] Of these 200,000 students, approximately 20,000 were already receiving services off-site for various reasons. In addition, a small number of students who received services in non-church affiliated private schools continued to receive Chapter 1 services at their schools.

The Department of Education's Center for Education Statistics reported 330,000 students served, but that figure is generally regarded as too high. The Departments Chapter 1 program office reports 184,532 private school students served in 1984-85, but that is too low. Given the importance the number has assumed in the distribution of the capital funds, we should look more closely at the problems with the figure. Some of the more important is:

1) Several states, like George and Arizona, estimated the total participation in Chapter 1 by sampling a few districts. The sample was not verified to reflect nonpublic school enrollments. Many states attempted to conduct a universal census of all LEAs, but frequently failed to obtain all the needed data by the Chapter 1 reporting deadline, and so reported only partial returns without estimating nonrespondents. Some LEAs failed to return the census information, or failed to fill out the report completely, or misunderstood the question on participation, or under counted or overcounted children receiving more than one Chapter 1 service. Thus, the totals of public school participants varied by as much as 30% from year to year in the same state. Because the numbers of participants were so much smaller in the nonpublic sector, the variation from year to year for all these accidental reporting reasons was greater still.

[2] In 1983-84, the year before what is now considered the pre-Aguilar base year, the Chapter 1 office figures for nonpublic school student participation were 225,000, or 41,000 more participants than were reported for 1984-85. The Chapter 1 program office figures are supposed to be actual counts by the state, not samples, and the most likely reason for such fluctuation—apart from large-scale changes in the program that we know from our program coordinators did not occur—is undercounting by the states when LEAs failed to file their reports by the deadlines. For that same year, the Center for Educational Statistics survey found 325,000 nonpublic school Chapter 1 students. This survey is considered less reliable because it was a sample based on the responses of nonpublic school administrators, who might have misunderstood certain of the questions regarding participation. However, the same objection could be made to the LEA and SEA responses, which are clearly in error in some cases. Altogether, these various surveys and their conflicting numbers establish a range for the level of participation of nonpublic school students, and suggest that we cannot be certain about the actual number of participants before Aguilar. The range is from 184,000 to 325,000 private school participants. Richard Jung, OERI, "Aftermath of Felton: A National Perspective."

[3] Babette Gutmann and Allison Henderson, "A Summary of State Chapter 1 Participation and Achievement Information for 1985-86" (U.S. Department of Education, Contract 300-86-0094, March 1988); Richard K. Jung, "Interim Report of the National Assessment of Chapter 1" (U.S. Department of Education, January 1986); Jung, "The Aftermath of Felton: A National Perspective," A research report to the American Education Research Association, (Washington, D.C., April, 1987); also Jung, "Changes in participation in Chapter 1 for public and non-public school students, 1979-1987", unpublished tabulations. The latter two research presentations drew on the Department of Education's Fast Response Survey System. Finally, data for the year 1987-88 were provided by Carol Chelemer of the U.S. Department of Education from individual state reports.

[4] Throughout this discussion, we will make reference to a study we commissioned of the problems Aguilar has caused for our schools and eligible students. Thomas Vitullo-Martin, Ph.D., and William McCready, Ph.D., Metroconomy Study of Chapter 1 Services in Catholic Schools After Aguilar, Prepared for the United States Catholic Conference, May, 1989.

[5] Gutmann and Henderson, table 1.8

[6] As of May, 1989, the Department of Education has received reports from 42 states, the District of Columbia and Puerto Rico, but not from 8 other states.

[7] The distribution of services has been calculated from the percentages presented by Richard K. Jung, "Talking Points," op. cit., table A-3.

Table 2a: Cost of Delivering Chapter 1 Services to Priate School Students After Aguila.
Expenditures to 1988

Location	Number of Students	Transportation Costs (in $ millions)	Site Costs (in $ millions)
Distant Sites			
Public schools	15,000	10.5	--.--
Neutral sites	35,000	10.5	12.5
Adjacent Sites			
Van	16,000	--	16.
Mobile unit	15,000	--	9.3
On-Site			
Computer (site prep)	20,000	--	7.5
(off-site meeting room)	--		5.
Total	75,000	21.	50.

Table 2b: Cost of Delivering Chapter 1 Services to Priate School Students After Aguilar
Current Requirements

For Students Not Served			
Vans	75,000	--	60.
Convert Unworkables Sites			
Vans	25,000	--	20.
Total	100,00	--	80.

STATEMENT OF THE ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION

Chairman Harkin and distinguished members of the subcommittee, this testimony is being submitted on behalf of the Association fore Gerontology in Higher Education (AGHE). AGHE is a nonprofit membership organization of over 300 institutions of higher education that conduct research and provide training and education in the field of gerontology.

Once again, we are at the start of a new legislative cycle. We all have many hopes and expectations for the incoming administration. Of particular concern to this Association, are the educational needs of our aging society. Since education is also a priority of President Bush, we hope to see great strides in the improvement of the quality of our educational system generally and in the expansion of gerontology as a field of study specifically over the next four years.

This testimony will address the proposed FY 1990 budgets of the Administration on Aging, Title IV (OAA) programs; the Health Resources and Services Administration, Bureau of Health Professions; the National Institute on Aging; and the National Institute of Mental Health, Mental Disorders of the Aging Branch. We would like to begin by thanking this subcommittee for its support of these four agencies over the past several years.

Recommendations for FY 1990.

AOA-TITLE IV. This Association is strongly opposed to the Administration's generic appropriation request for all OHDS research and training programs, including Title IV of the OAA. We oppose such consolidation of funds, on the grounds that it would lessen accountability on the part of individual agencies, and decrease federal commitment to education and research and obscure program visibility. The recommendation of this Association for Title IV (OAA) is a modest increase of 10 percent to $27,500,00. This small increment in the funding level would partially account for past inflation and serve to bolster the program. There has been no increase in Title IV funding since FY 1985. Moreover, the program has had to endure across-the-board funding cuts mandated by Gramm-Rudman sequestration. Since Title IV is the only federally supported program designed to fund research and training for the social/behavioral needs of older Americans, these budgetary reductions have effectively thwarted growth in this area.

HRSA-Bureau of Health Professions. This Association is diametrically opposed to the Administration's proposal that all funding for health professions within this Bureau be eliminated. Every segment of our society is at risk when we forsake the education and training of medical personnel. While major advances have been made and continue to be made through scientific research on various diseases, this knowledge has no practical application without medically trained individuals who can implement the findings. We implore Congress to maintain at minimum the current level of funding for the Bureau of Health Professions.

We would like to emphasize a program which has become a critical component in the education of personnel in the field of aging, Geriatric Education Centers - funded under the Public Health Service Act (Section 788(d)). These centers have been established to facilitate training in medical, dental, optometric, pharmacy, podiatric, nursing, and appropriate allied health and public health faculty, students, and practitioners in the diagnosis, treatment, and prevention of diseases and other health problems of the aged. In FY 1988, thirty-three of these regional resource centers were supported at a level of $9.5 million dollars. The sudden cessation of these centers, as designated by the President's FY 1990 budget proposal would effectively thwart any Congressional attempt to adequately meet health-related personnel needs in the field of aging.

National Institute on Aging. With respect to NIA, AGHE recommends an FY 1990 funding level of $383.5 million. This sum would enable the agency to adequately fund applications and proposals which have already been approved. This funding level which is $153 million greater than that proposed by the President, would also allow for increased emphasis upon the training of new investigators. Historically, training funds have been the smallest component of the Institute's budget. The funding level proposed by AGHE would enable NIA to triple its current expenditure on training activities.

Once again, Congress must confirm its commitment to the education of personnel who can conduct research studies and implement their findings. While we wholeheartedly support increased budgets for research, we can not emphasize enough the need to simultaneously plan for the future by funding education and training programs for professionals working in the rapidly expanding field of aging.

In an issue related to the need for increased education and training, this Association would like to remind Congress of the fact that while NIA's budget has doubled over the past 5 years, staffing levels have been cut 7 percent. Again, we are faced with a situation in which research programs are being expanded without the necessary personnel to oversee their operation.

NIMH, Mental Disorders of the Aging Branch. This Association recommends a budget of $84.9 million for research in the field of aging mental health. We believe that this $30 million increase in expenditures from FY 1989 is necessary since unlike other types of illness, mental illness has few non-federal sources of research support. This amount would also allow for an increase in the number of both clinical and research training positions. Conversely, the President's proposed budget of $57.5 million would not enable any growth either in research or training programs.

Conclusion

This Association is acutely aware of the financial constraints facing our nation. However, upon entering the final decade of this century we must not overlook our responsibility to plan for the year 2000 and beyond. We believe that one of the best uses of our limited financial resources is in the area of education. The promises awaiting us in the 21st century will only be realized, if we have the knowledge and capability to understand and effectively deal with an increasingly complex world.

STATEMENT OF ROBERT D. EVANS, AMERICAN BAR ASSOCIATION

I am Robert D. Evans, Director of the Governmental Affairs Office of the American Bar Association. I submit this statement on behalf of the Association at the request of our President, Robert D. Raven, to express our support for the continued funding of the Council on Legal Education Opportunity (CLEO) and the clinical legal experience program.

These two programs are modest in size, CLEO receiving $1.8 million and the clinical legal experience program $3.9 million for the current fiscal year. But they have an impact which goes far beyond their small size.

The Council on Legal Education Opportunity has been a major factor in the dramatic rise in the number of persons from disadvantaged backgrounds, particularly minorities, receiving a legal education. Our Association joined with other concerned organizations in 1968 to create CLEO as a means of addressing the problem of the underrepresentation in the legal profession of minorities and other disadvantaged persons. The program has sought to identify such persons and encourage them to apply to law school; to provide special pre-law school training to assist their entry into law school and their performance once enrolled; and to aid them financially while there.

When the program began in 1968, only one per cent of the nation's lawyers were members of minority groups. That figure has grown to more than 4%, and the figure continues to rise as the number of minorities entering law school increases each year. The percentage of minorities in the first year class at the nation's law schools this year is 13%, up from 12.2% last year. Minorities now make up 11.6% of the law school student body nationally, up from 11.2% last year.

CLEO has provided the opportunity for over 4800 students to attend law school. But beyond the students it has aided directly, the program has served to encourage law schools to increase their own efforts to ensure that all segments of society will be adequately represented in their student bodies and, ultimately, in the legal profession.

In 1986 CLEO was reauthorized to continue in existence through 1991, with authorization ceilings of $5 million for FY 87 and "such sums as may be necessary" thereafter. The Reagan/Bush recommendation for FY90 calls for $1.95 million for CLEO, which if approved would represent a slight increase for the program form last year. Final FY 89 appropriations by both the House and Senate had included $1.95 million for CLEO. However, the final figure recommended by the Conference Committee was $1.89 million, a slight reduction from the previous year.

While these amounts have enabled CLEO to continue to provide support to minority law students, CLEO stipends have significantly declined as a proportion of overall support when measured against steep increases in tuition and other costs over the past decade.

We support the requested appropriation of $2.5 million for FY90. This increase will permit first year CLEO fellows to receive stipends of $3000 rather than $2200, and second and third year fellows $2400 rather than $2000, in the coming year. This amount remains well below the stipend amounts under other federal programs for graduate and professional students, which currently provice assistance of $6000 or more. Even with this modest increase, support for CLEO fellows will remain far below the 1974 inflation-adjusted level of CLEO stipends. This worthy, cost-effective program deserves and needs this modest increase.

The clinical legal experience program, which is currently funded at $3.9 million, is a much-needed supplement to the resources being spent each year by law schools on clinical legal education. These clinical programs, like their counterparts in the medical schools, permit the student to gain experience in the actual provision of services to those in need and to assume the professional responsibility of making decisions vitally affecting their clients. Clinical experience thus provides an invaluable ingredient in the student's training, greatly strengthening his or her ability to provide quality legal services to consumers upon graduation.

Such programs, however, necessarily involve close supervision and review of the students by law professors and practicing lawyers, and the student-teacher ratio must be far lower than in a conventional classroom teaching arrangement. Currently, 448 faculty members are devoting all their time to clinical professional skills programs and 1368 faculty members are devoting part of their time. While the law schools have diverted funds

We believe this program has demonstrated clearly its effectiveness and should receive ongoing funding, and we urge your subcommittee to support an appropriation of not less than the current $3.9 million.

STATEMENT OF DAVID O. IVES, VICE CHAIRMAN, WGBH EDUCATIONAL FOUNDATION

Thank you Mr. Chairman for the opportunity to bring to your attention a new project developed by WGBH that will make television more understandable and accessible to America's twelve million visually impaired, a number that includes people that are legally blind as well as those that are experiencing diminished sight as a result of aging. It is called Descriptive Video Services, or DVS.

The issue of access is a pivotal issue in the handicapped community. Physical access to buildings, equal access to jobs, technical access to computers and technology, are all part of the larger issue of "equal access" for all citizens. Included in this issue *must* be access to the arts: whether it's to the theater, movies, print or television. Equal access will indeed be the issue of the 1990's and beyond.

Television is a particularly significant part of our society and culture. In this ever-changing global environment--the so-called information or video age--it is more critical than ever that all citizens have access to television. Specially adapted technologies such as radio reading services, utilizing FM sub-carriers, have made print available to the visually impaired but never have they had access to the visual medium of television.

A study conducted by the American Foundation for the Blind reported that blind people pay as much attention to television as sighted people. In fact, most people who are visually impaired live with sighted persons and live with the sound of the television set turned on in their home. But the blind say that trying to watch television is difficult and frustrating. One need only imagine watching television for a few minutes with your eyes closed to experience this frustration first hand. Descriptive Video Services will reduce those frustrations and contribute to the independence of blind people, allowing them to rely less on friends and relatives who can see.

HOW IT WORKS

By utilizing new television stereo technology, (Multi-Channel Television Sound), DVS provides descriptions of the key visual elements of a television program. The descriptions are inserted during pauses in the program dialogue and are broadcast on the Separate Audio Program (SAP) channel, a standard feature on all stereo television sets and stereo VCR's. The viewer needs no additional device or decoder. This "extra" sound track is heard only when the SAP channel is selected. The viewer who does not need the descriptions would not select the SAP channel and would therefore not hear them.

The technology to bring DVS into people's homes is already in place. The Electronic Industries Association reports that there are currently over 15 million stereo TV and stereo VCR's in homes and estimates that 40% of all new television sets purchased this year will be stereo. On the Public Broadcasting Service, where we propose to launch DVS, 26% of American TV households are able to receive DVS today. Each month, more and more stations add stereo to the broadcast signal.

HISTORY OF DVS

DVS has been in research and development since 1985. A local Boston test funded by the Easter Seals Research Society was conducted in 1986. In 1988 we created a DVS department and conducted a national test of the service. This national test was conducted with the cooperation of the Public Broadcasting Service, the *American Playhouse* national series, a metropolitan Washington, D.C. radio reading service organization, The Washington Ear, and ten public television stations: WETA, Washington, D.C.; WSRE, Pensacola, FL; WGBH, Boston, MA; WCBB, Lewiston, ME; WNET, New York, NY; WXXI, Rochester, NY; WBGU, Bowling Green, OH; WVIZ, Cleveland, OH; WMVS, Milwaukee. WI; and KERA, Dallas, TX.

Descriptions were produced for 29 consecutive episodes, the entire 7th season of *American Playhouse*, a PBS series presenting the finest in American drama. The purpose of the test was three-fold: 1) to demonstrate that descriptions could be produced in a timely manner and within regular production schedules; 2) to demonstrate that a third audio (SAP) signal could be readily transmitted via satellite to local stations and that the signal would not interfere with the regular broadcast audio and closed captioned information; and 3) to determine on a national scale, if blind viewers who experienced the service found DVS to be helpful in making television understandable and enjoyable.

We are pleased to report that the test was successful on all counts. All 29 episodes of *American Playhouse* were described and no deadlines were missed or inordinately delayed. The DVS sound track was successfully transmitted, week after week, via satellite to all participating stations who reported no difficulty in recovering and retransmitting the signal on their local SAP channel. There were no significant technical problems encountered. In fact, that season of *American Playhouse* enjoys the distinction of being the first television broadcasts anywhere that were accessible to both visually impaired and, with closed captioning, hearing impaired consumers. And most importantly, visually impaired people in all test cities were overwhelmingly positive and enthusiastic about this potential new service. We found it necessary to continually stress to viewers that this was a test of DVS, not yet a permanent service. We were concerned that visually impaired people would purchase new stereo TV receivers and then be frustrated once again when the test was over and new programming not available.

Concurrent with this national test, The Corporation for Public Broadcasting provided funds for the development of a business plan that determined the operational needs of a permanent service, a long-range funding strategy, and start-up and operational costs for running the service. This business plan has become our blueprint for launching DVS on public broadcasting this Fall.

THE COST OF DVS

By carefully analyzing the process of producing described programming for television we have determined that the launch of a permanent DVS service will cost approximately $1,300,000. This figure is based on describing five hours of dramatic programming each week, equal to 260 hours of programming annually.

The tasks necessary to launch a regular, permanent service can occur in two phases: start-up and operational. During the start-up phase, costing approximately $300,000 we will continue on-going development of an efficient, computer-based DVS workstation, define descriptive techniques, hire and train describers, and develop cost-effective encoding and transmission procedures in conjunction with PBS Technical Operations. We will also conduct a major outreach effort to inform the visually impaired community, television receiver manufacturers, the press and local and national service organizations for the visually impaired about the service.

An initial annual operating cost of $1,000,000 will allow for continued refinement of describing techniques, promotion and outreach to the audience that will be served by DVS and, primarily, the describing of 260 hours of dramatic programming on PBS. If DVS were to be launched at a level less than this, it would not be cost-efficient, it would not really be a service and it would not support the necessary outreach and development activities that such a service requires. It must not become a broken promise to the blind community. It is our responsibility to assure its long term viability.

We look to the Federal Government for support during the initial years of DVS. We do not, however, envision federal funds as the only means of support and, for the long term, will seek to develop a service that has a mixture of funding from private foundations and corporations as well. Solicitations of the private sector have, in fact, already begun.

Since drama is the program type most requested by far by blind viewers, the first described programs will include: *American Playhouse, Mystery!, Degrassi High, and Masterpiece Theatre.*

THE LEGACY OF CAPTIONING

In many ways the history of closed captioning for the hearing-impaired is a model for the development of DVS. Both closed captioning and DVS serve citizens who cannot enjoy television without special accommodations. Television captioning, which was first developed at WGBH in

1971, was supported initially by federal funds. While federal dollars are still required for captioning, that money has leveraged an increasing amount of private support, and today, 95% of all prime-time broadcast programming is captioned. There is no reason why DVS would not follow a similar path.

SUPPORT FROM THE VISUALLY IMPAIRED COMMUNITY

DVS has received enthusiastic encouragement and endorsement for its efforts. The Council of Citizens with Low Vision and the Bay State Council of the Blind have passed resolutions supporting DVS. These endorsements also come from individuals.

One blind viewer who saw the first DVS broadcast of *American Playhouse* wrote: "My first experience with DVS was very emotional. I found myself pacing the floor in tearful disbelief. It was like somebody had opened a door to a new world, in which I was able to see with my ears what most people see with their eyes."

And one blind teenager said that DVS was, "Awesome!"

CONCLUSION

Since 1985 we have developed the DVS concept. We have demonstrated it nationally to thousands of blind and low vision people. The technology is in place, the programming is available, the public television network and stations are ready. Only one element is missing to launch DVS now, and that is federal appropriation of the necessary $1,300,000. Such a relatively small amount of money will not only open the window of television to 12 million sight impaired Americans, but it will soon be followed by substantial contributions from the private sector. I strongly urge the committee to provide this vitally-needed initial funding.

STATEMENT OF RECORDING FOR THE BLIND, INC.

Recording for the Blind (RFB) is a nonprofit educational service organization which is the only national resource in the United States providing, free of charge, textbooks on cassette tape to blind and other print-handicapped students at all educational levels, from fifth grade through postgraduate training.

RFB was founded in 1948 by Anne T. Macdonald to help blinded World War II veterans take advantage of educational opportunities under the G.I. Bill. Before that time, blind students rarely attended college. Since its establishment RFB has evolved to be the primary source of educational material for print-handicapped students of all ages (except the very young), in all fields. RFB's guiding principle is that print-handicapped individuals must have available to them any educational texts that are available to their sighted and able-bodied peers, including law, medicine, sciences, mathematics, and foreign languages. RFB believes access to "learning through listening" is a right, not a privilege.

RFB has a Master Tape Library of 72,000 titles, which increases each year by the more than 3,000 new books recorded by 4,000 volunteers each year, at 31 recording studios in 16 states and the District of Columbia. Through RFB, blind and other print-handicapped citizens in all 50 states have access to the largest and most comprehensive collection of recorded books anywhere in the world. Last year RFB provided 137,000 taped books to more than 24,000 borrowers. Some 95 percent of these were shipped to borrowers within 48 hours of the request.

The demand for taped texts is growing at a rate of seven to nine percent each year. Increasingly, requests are for technical books in science, mathematics, and engineering. In earlier years the bulk of the texts recorded were in the liberal arts such as classical literature, history, and the social sciences. Since most of the classics are now available from RFB's Master Tape Library, and since blind students are more and more entering specialized fields, the recording emphasis has shifted; now some 60 percent of the books recorded are in scientific areas which require three times as long to record as nontechnical books, and must be periodically revised in new editions.

To help meet this growing demand and prepare for the future, RFB recently completed an equipment modernization program to expand its computer system, install automated library shelving, and purchase state-of-the-art tape duplicating equipment. New recording studios have been opened in Boston, Connecticut, Los

Angeles, and Philadelphia which are devoted to the recording of technical and scientific books. Although RFB is heartened by the dramatic increase in demand for science and technical books among blind students, the cost burden to RFB increases substantially, year by year.

RFB provides, through the private sector, an essential educational service - a library resource, free of charge to borrowers - which the Federal government or state governments would otherwise be required to provide. Because of its nationwide network of 4000 trained volunteers, RFB can fulfill its mission more efficiently, more effectively, and with far less expense than a government agency.

Two complementary (not duplicative) educational organizations - the Library of Congress' National Library Service for the Blind and Physically Handicapped, and the American Printing House for the Blind, are supported exclusively or primarily through federal funds. In contrast, RFB was able to raise $4.1 million from private sources in 1987, and received sole source contract funds of $540,000 from the U.S. Department of Education's Office of Special Education Programs. Although Congress earmarked $850,000 of OSEP funds for RFB in the FY 1989 appropriation, RFB's headquarters' expenses alone will total over $4.5 million for the year. The expenses of the satellite recording units will add $1.8 million. Even with increased funding, RFB will experience a deficit in 1989 for the first time in 12 years.

As the primary nationwide source of recorded texts for blind and other print-handicapped students, RFB must continue to meet the growing demand; it is no exaggeration to state that a college education would be extremely difficult, if not impossible, for any blind student without the free borrowing services of RFB and its fast response time enabling blind students to compete in class with their sighted peers.

When RFB first received a Federal contract in 1975, the

$500,000 amount provided about one-third of RFB's support. Since that time, demand (and expense) have increased to the point that even with the substantial increase Congress provided for FY 1989, the amount will provide less than 14% of RFB's operating budget. RFB will continue to rely mainly upon private sources of funding, and revenues from these sources are expected to expand in the future; but an expanded and stable commitment of Federal support, commensurate with the national interest in maintaining the unique services RFB provides, is essential to assuring excellence in education for blind students.

Since RFB is in the business of preparing print handicapped persons to lead independent lives and to become productive citizens in the nation's economic mainstream, RFB's service indirectly produces revenue for Federal, state and local government by enhancing employment opportunities for the blind, and thereby provides tax revenues for these governments. Public Law 94-142 requires the Federal government to provide educational services for all handicapped children. As mentioned previously, if RFB did not exist, government would have to provide the services but could do so only at great expense if indeed it could do so at all. Therefore it is reasonable and fair for the government to share a significant proportion of the cost of RFB's operation. RFB urges an appropriation of $2.0 million for FY 1990, an amount which would provide about 31% of RFB's total expenses.

STATEMENT OF RICHARD FOULDS, PH.D., RESNA, INTERDISCIPLINARY ASSOCIATION FOR THE ADVANCEMENT OF REHABILITATION AND ASSISTIVE TECHNOLOGIES

Introduction

Mr. Chairman, it is a pleasure to present testimony on the concerns of the field of assistive technology. My name is Richard Foulds. I am a rehabilitation engineer and been active in the field of assistive technology for many years. I am currently the President of RESNA, an Interdisciplinary Association for the

Advancement of Rehabilitation and Assistive Technologies and this testimony today is on behalf of RESNA.

RESNA: an Interdisciplinary Association for the Advancement of Rehabilitation and Assistive Technologies.

RESNA is concerned with transferring science, engineering, and technology to the needs of persons with disabilities. Our Association and the over 1000 individuals it represents welcomes the opportunity to comment on issues related to the proposed fiscal year 1990 funding for the Technology-Related Assistance for Individuals with Disabilities Act, (P.L. 100-407). Our members are rehabilitation professionals from all pertinent disciplines, including clinicians, manufacturers, providers and consumers. Our goal is to promote and support the research, development, dissemination, integration, and utilization of knowledge in rehabilitation technology and to assure that these efforts result in the highest quality of service delivery and care for all persons with disabilities.

The Technology-Related Assistance For Individuals with Disabilities Act (P.L. 100-407)

Access to assistive technology has been a top priority for both persons with disabilities and rehabilitation professionals. Therefore, RESNA members were delighted when P.L. 100-407 became law in August 1988. This legislation has generated great interest and has already had an impact on assistive technology services in the states. In anticipation of the funding for this program many State and local agencies and community agencies are working together and sharing information on existing resources and services, as well as identifying gaps in the present system.

In order to capitalize on this legislation, critically needed financial and technical support for the development of these consumer responsive assistive technology services must be available.

The development and provision of technology has long been accepted as an integral part of the rehabilitation process in this country. Wheelchairs crutches and braces, etc. have been available to people with physical disabilities for many years. More recently, advances in engineering developments are resulting in more sophisticated assistive devices for disabled people with physical or mental impairments - both congenital and acquired. Individuals who have difficulty with mobility, sitting, verbal expression or hand function, or hearing or vision impairments can now substantially benefit from new and emerging assistive device technology. Comparative studies and direct observation have shown time and again the value of assistive devices in providing improved function, increased independence, access to educational/vocational pursuits; and most importantly, a life of economic and personal fulfillment. Service delivery for assistive technology is not simply a matter of purchasing a device and giving it to the person who has to use it. It requires information, an ability to provide appropriate evaluation and training, and knowledge of the complex payment and reimbursement systems. The major barriers that prevent access to these new technologies for the vast majority are due to the total absence of, or fragmentation of, this type of delivery system and its associated payment structure.

RESNA strongly supports the provisions of Title I of the Act in establishing a competitive grant program to assist states in developing and implementing consumer responsive statewide systems of technology related assistance. RESNA was disappointed that Title II funding for programs of national significance, technology training, public awareness, and the study on the financing for assistive devices, was not funded.

Impact:

Funds are needed at the authorized level. This legislation has great promise for many people with disabilities but must be funded adequately before its promise can be realized. Funding at the authorized levels will enable the states developing programs, and people with disabilities the opportunity to test the validity of this program. With inadequate funds this would not occur.

If only a few states are funded there will be significant delays in the development of coordinated systems of service delivery, and the limited resources for technical assistance will discourage states from participating in the competition.

Recommendations:

RESNA recommendations: RESNA recommends $20 million, the authorized amount for Title I for grants to States and $6.5 million for Title II, Programs of National Significance in FY 1990.

Justification:

With the passage of P.L. 100-407, Congress acknowledged the powerful role that assistive technology can play in maximizing the independence of people with disabilities. This program is intended to be a catalyst for statewide system changes to increase access to appropriate assistive technology devices and services. The success of this effort depends on the full participation and cooperation of the states in developing comprehensive, coordinated systems of service delivery. Without adequate funds to implement the program, the states' progress will be impeded, and people with disabilities will continue to be denied access to the tools they need to receive an education, seek gainful employment and participate fully in society.

Conclusion:

It is indeed encouraging to see the possibilities that technology holds for individuals with disabilities, and to be a part of the incorporation of technology services into comprehensive rehabilitation efforts. RESNA applauds your efforts to ensure that disabled citizens of all ages have access to the benefits of technology, and we look forward to working with you to achieve that goal. As an association comprised of rehabilitation professionals, educators, manufacturers, suppliers, and consumers, we feel well qualified to participate in this process.

Mr. Chairman, I appreciate the opportunity to present these comments and respectfully submit them to the record.

STATEMENT OF STEPHEN S. BARRETT, DIRECTOR, HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTH AND ADULTS

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to present testimony in regard to our request for continued support for the Helen Keller National Center for Deaf-Blind Youths and Adults (HKNC). For the record, my name is Stephen Barrett, Director of the Helen Keller National Center.

My purpose is to provide you with brief background information on the history and goals of HKNC, recent accomplishments, our goals for the coming year, and fiscal implications. I wish to address very specific service priorities in terms of their benefit to persons who are deaf-blind, their implementation, and why we feel they will have an important impact on services on a national basis.

The Helen Keller National Center is funded exclusively by Congress. For fiscal year 1990 the Bush Administration has proposed level funding for HKNC in the amount of $4.841 million. There is no inflationary increase proposed, which concerns us very much. Of equal concern is the fact that the amount appropriated for FY 1989 was essentially the same as for FY 1988. Thus, if the President's request for FY 1990 is accepted by Congress, HKNC will have had imposed on it a freeze in funding for three years.

We are asking Congress to provide funding at the level of $5.6 million level so HKNC can recoup from two years of level funding, and so that we may expand services in several key areas which are described herein.

AUTHORIZATION AND PURPOSE

The Center is authorized under Title IX of the Rehabilitation Act Amendments of 1986 and operates under the general supervision of Rehabilitation Services Administration, OSERS, U.S. Department of Education.

The purpose of the Helen Keller National Center is to provide a national program of rehabilitation services to America's estimated 40,000 persons with deaf-blindness. We accomplish this in many ways. During the twelve month period ending June 30, 1988 the Center served over 2700 persons through its rehabilitation center based at its headquarters on Long Island, New York, its ten regional offices located throughout the nation, and its national network of 28 affiliates based within public and private agencies.

FUNDING REQUEST

If funding is approved in the amount of $5.6 million it will allow us to accomplish the following goals:

1. EXPAND EMPLOYMENT TRAINING PROGRAMS

At present we are limited in the number of employment sites we can establish only by staff limitations. The model of Community Work Experience we utilize, based upon Supported Employment theory, has already been proven effective. We are requesting funds to add two Employment Training Specialist positions who will work directly with our clients on the job site. This will allow us to double the number of job training sites in the community and the number of persons served.

2. ADD "SUPPORTED LIVING" SERVICES TO CURRICULUM

Although there are several thousand persons with all sorts of disabilities served by supported living programs throughout the nation, few, if any, are as severely disabled as persons with deaf-blindness. HKNC would establish a national model of supported living for deaf-blind clients which would also be replicated in other parts of the nation through HKNC's Field Service Programs.

3. INCREASE SERVICES THROUGHOUT THE NATION

Last year we have begun a process of adding a second person to each regional office based upon recommendations from Rehabilitation Services Administration, the governmental office under whose supervision we operate. Two new staff have been added, one each to our Atlanta and Seattle offices, and we added a third position which will serve as a Specialist for Elderly Persons with Deaf-blindness.

If funding is approved, we would add three new positions to our regional offices in order to gradually increase the number of staff in these positions. The result will undoubtedly be a measurable increase in the numbers of persons served in their local community.

We would also expand our national Affiliate Network which last year served over 1,600 persons. HKNC provides seed money on a temporary basis to public and private agencies in order to assist them in developing specialized projects to serve persons who are deaf-blind.

4. IMPROVEMENTS TO PLANT AND MAINTENANCE

HKNC's facilities were constructed with funding provided by the federal government and the government retains ownership of the buildings, furnishings, and grounds.

Our current facilities, though modern and well maintained, could benefit from modern technology to effect energy cost savings. Our furnishings in many parts of the three buildings on campus are the original ones installed in 1976. We have begun a plan of action to gradually replace worn equipment and furniture. Our residence building, which provides room and board for a maximum of 52 clients, is badly in need of new furnishings.

5. MEET THE ANTICIPATED REQUIREMENTS OF A NEW BARGAINING AGREEMENT

Our current union agreement is up for negotiation this spring. We anticipate the settlement will call for at least a 4-5% increase in salary, which also increases our cost of fringe benefits. Without funding to help cover these increases and the normal inflationary increases expected from year to year in any organization, our only alternative would be to eliminate vital staff positions.

REQUEST FOR INCREASED APPROPRIATION

HKNC respectively requests an appropriation for fiscal year 1990 of $5.6 million, as opposed to the Bush Administration's request for level funding of $4.841 million.

The requested appropriation will allow HKNC to continue a role of national leadership in providing services of the highest quality to deaf-blind persons in America.

CONCLUSION

Individuals with deaf-blindness are perhaps the most severely handicapped population known to mankind. The Helen Keller National Center for Deaf-blind Youths and Adults provides the highest quality services possible in a program which is internationally recognized as a leader in the field of Vocational Rehabilitation.

On a national basis we are proving everyday that people who are deaf-blind can lead meaningful lives living and working alongside their fellow members of the community. The financial costs of rehabilitation can be measured and the return on every dollar spent has been proven to be a remarkable investment repaid many times over as tax consumers become taxpayers.

Each year brings new ideas, service strategies, and increased opportunities for persons who are deaf-blind. There has been considerable growth at Helen Keller National Center in terms of both the quantity and quality of services provided. We need your continued support to help people who are deaf-blind attain the same quality of life we desire for ourselves.

STATEMENTS OF DOROTHY GORDON, AND THEODORE COLE, M.D., AMERICAN CONGRESS OF REHABILITATION MEDICINE

I am Dorothy Gordon, D.N.Sc., an Associate Professor of Nursing at Johns Hopkins University School of Nursing and I am accompanied by Theodore Cole, M.D., Chairman of the Department of Physical Medicine and Rehabilitation at the University of Michigan. I am the President elect of the American Congress of Rehabilitation Medicine and Dr. Cole is a Vice President and Board Member. We are testifying for the Congress, the American Academy of Physical Medicine and Rehabilitation, and the Association of Academic Physiatrists. The Congress is a multidisciplinary organization of about 3,000 members dedicated to fostering research, education and comprehensive, interdisciplinary medical rehabilitation services for the physically disabled. The Academy is the medical specialty society representing the approximately 3,500 physicians and residents in the field of physical medicine and rehabilitation and the Association of Academic Physiatrists is an academic medical society.

Rehabilitation medicine involves the diagnosis and treatment of physically disabling conditions of physically disabled persons to minimize the disabling effects of disease or trauma and restore physical, as well as psychological, social and vocational function. The physically disabled with whom we work have neurological, muscular and musculoskeletal disabilities such as stroke, arthritis, head injury, spinal cord injury, multiple sclerosis, cerebral palsy, amputations and congenital limb deficiencies such as spina bifida. Rehabilitation medicine therefore is involved with catastrophic illness. The disabled treated include all age groups and many individuals are covered by Medicare and Medicaid. For example, 70% of Academy members are participating physicians in the Medicare program. We are concerned with assuring that severely disabled individuals regain their capability to walk, to communicate, to dress and eat independently, to engage in physical exercise, and most important, to return to work or home and independence. Our positive contributions to society are measured by the numbers of courageous disabled people of all ages who return to work or school or at least live independently.

Stroke research at the University of Washington, Seattle, established that an inpatient rehabilitation program for stroke patients resulted in 75% of patients living independently after a six month follow up even though over 60% had been institutionalized before the program. Comparable research has shown similar effectiveness regarding the management of spinal cord injury with lessened hospital stays and much lower death rates. Initial hospital stays have been reduced by about 1/3 in a decade.

Since World War II medical rehabilitation has been good business for society and this is true today more than ever.

The growing relevance of rehabilitation medicine is nowhere better exemplified than in the care of our increasingly aging population.

T. Franklin Williams, M.D., currently Director of the National Institute on Aging, has written "The aim of rehabilitation to restore an individual to his or her former functional and environmental status or to maintain or maximize remaining function should be at the heart of all care for aging persons...".

Let me provide you with some brief data on the numbers of severely disabled people and their potential cost to society if not rehabilitated effectively. About 500,000 Americans have strokes each year, and while 155,000 die, half at least are alive seven years later although often with impaired mobility, strength and communication ability. A total of 2 million Americans suffer from stroke and it is estimate that in 1987 the cost of stroke in lost productivity and health care costs was about $13 billion. About 37 million people suffer from disabling arthritis at a cost to society of $9 billion dollars. About a quarter of a million Americans have multiple sclerosis and the cost to society is great, estimated at $2 billion a year. Trauma is estimated to affect some 60 million Americans a year with 9 million being temporarily disabled and 340,000 permanently disabled. Head injury and spinal cord injury are the major examples of severe disability induced by trauma. The Institute of Medicine Report "Injury in America" (1985) indicates that injury is the leading cause of disability with motor vehicle injuries alone resulting in a cost to society of $36 billion in 1980, second only to cancer. The Report indicates that 75,000 Americans a year sustain brain injuries resulting in long term disability and 6,000 each year are discharged from hospitals with spinal injury and either paraplegia or quadriplegia. Another recent Institute of Medicine study indicated that the total costs from disability for the under 64 population alone doubled from 1970 to 1982 and was $121 billion in 1982. Now it is probably $150 billion.

We are testifying before you today in support of the rehabilitation programs administered by the Department of Education and the research programs of the National Institutes of Health (NIH) related to rehabilitation. Those programs are essential in order that we maintain and develop further our capacity to effectively rehabilitate the disabled. The organizations for which we testify are part of the National Rehabilitation Coalition and we endorse the Coalition recommendations for appropriations for rehabilitation programs in the Rehabilitation Act.

Department of Education Programs

Training Programs Supported by RSA

The country faces a very serious shortage of rehabilitation nurses, physical therapists, occupational therapists, speech pathologists, and of physician specialists in physical medicine and rehabilitation. Hospitals are actively seeking additional personnel in all of these areas. The training program of Rehabilitation Services Administration (RSA) may not be adequate to meet the needs of these fields, even at full funding, given the other important priorities of the program. Funds have not been available for most of these fields from health training grants, for example, for nursing, physical medicine and rehabilitation and prosthetics and orthotics. We urge full funding of the program at $37 Million in order to assure some rate of growth for training in these many disciplines which have shortages. In 1989, $35 Million will be spent.

State Grants for Services and Independent Living Centers

We recommend funding of these programs at $1.7 Billion for the state VR grants and $49 Million for all independent living programs; representing an increase of about 15% and 10% respectively. We also which to highlight the need to expand the recently enacted technology assistance bill for the disabled. All of these programs assist in providing for increased independence and continued community living rather an institutional living for many needy disabled people. These programs are part of an ongoing service system which prevents unnecessary care and costs.

Research - NIDRR

Research in rehabilitation medicine involves a range of activity from basic science to clinical medical science and clinical trials, health services demonstrations, and technology development. Research activity also includes assistance in the application of research results through interaction with education programs and through liaison with service providers. Rehabilitation medicine is equally interested in the development of knowledge for independent living and vocational services, technology development and medicine. We therefore support the continuation and expansion of significant research support from the National Institute on Disability and Rehabilitation Research (NIDRR) at the Department of Education and from the NIH. The former focuses on vocational, psycho-social research and service demonstration activity and the latter on basic and clinical science in medicine related to rehabilitation.

We would urge the Committee to continue its longstanding and strong commitment to the NIDRR and fund it at $58 Million, which represents about an 8% increase over FY 1989.

National Institutes of Health

We would also urge a significant expansion of funding for the NIH in rehabilitation medicine. The NIH has reported that it spends about $107 Million on medical rehabilitation research by the latest count of which we are aware. A 75% increase in the estimate of funding occurred, however, when NIH used a broadened definition of rehabilitation. We are interested in that area of research activity which is focused precisely on the medical and related needs of the physically handicapped suffering from neuromuscular or orthopedic disabilities and their complications, such as arthritis, amputations, stroke and head and spinal cord injury. These conditions affect people of all ages and the restorative process involves various services and disciplines to enable the full development, of the disabled person. Children in their developmental stages are often involved where trauma such as head injury occurs or diseases such as spina bifida or cerebral palsy are present. Those over 65 are frequently the patients we see; they suffer from stroke, arthritis, amputation, etc. Rehabilitation medicine, like pediatrics and geriatrics, is not disease specific or organ system specific and it is truly an interdisciplinary activity involving the rehabilitation nurse, physical, occupational and speech therapists, psychologists, professionals who create and fit devices or equipment and physicians.

We believe that substantially less than the amount reported at NIH is truly devoted to the field we have described. We would urge a targeted expansion of funding by NIH to assure that the field is truly assisted. The need for this expansion has recently been recognized by the National Academy of Science (NAS) in a report on "Injury in America" and a report on pain and disability. We are also submitting a list of research achievements in medical rehabilitation derived from our various research centers.[1]

We would specifically recommend that up to $10 Million be added to the NIH budget to expand activity in medical rehabilitation research. This represents between a 5% and 8% increase over amounts expended in 1989 by our estimate since $107 Million was reported as being spent in 1987 and the rate of increase each year between 1987 and 1989 was 20%. We are asking for a lesser level of increase than has been spent in past years but we wish it to be targeted much more precisely. We would urge that up to $5 Million be provided to the National Institute on Child Health and Human Development for support of research training and research grants in the field of rehabilitation medicine. There is literally no research training program for this field now at NIH. Other research support should be provided to the Aging Institute, the Neurology Institute, the Arthritis Institute and the Nursing Research Center to expand their current activity but again to be targeted on clinical research projects and related basic science research with regard to the restoration of function in individuals with physical disabilities.

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[1] Please see attached table

STATEMENT OF V.M. SPEAKMAN, CHAIRMAN, RAILWAY LABOR EXECUTIVES' ASSOCIATION

My name is V. M. Speakman. I am President of the Brotherhood of Railroad Signalmen and a member of the Railway Labor Executives' Association. I appear before you as Chairman of the Association's Committee on the Railway Labor Act.

The Railway Labor Executives' Association is an unincorporated association with offices in Washington, D.C., whose membership consists of the chief executive officers of virtually all of the standard national and international railway labor unions in the United States. The organizations whose chief executive officers are members of the RLEA are listed below:

American Railway & Airway Supervisors Association (Division of TCU);
American Train Dispatchers Association;
Brotherhood of Locomotive Engineers;
Brotherhood of Maintenance of Way Employes;
Brotherhood of Railroad Signalmen;
Brotherhood of Railway Carmen (Division of TCU);
Hotel Employees and Restaurant Employees International Union;
International Association of Machinists and Aerospace Workers;
International Brotherhood of Boilermakers, and Blacksmiths;
International Brotherhood of Electrical Workers;
International Brotherhood of Firemen and Oilers;
International Longshoremen's Association;
National Marine Engineers' Beneficial Association;
Seafarers International Union of North America;
Sheet Metal Workers' International Association;
Transport Workers Union of America;
Transportation•Communications International Union (TCU)

We urgently request you provide the National Mediation Board with an appropriation which at least equals the appropriation provided it in FY 89; and, that you not permit a reduction in the funds which the National Mediation Board allocates to the National Railroad Adjustment Board and supplemental boards. If any reduction in the NMB appropriation is allowed to occur, the NMB, as the administrator of the National Railroad Adjustment Board and the supplemental boards created by the 1966 amendments to the Railway Labor Act, will place the entire burden of that reduction upon the services rendered employees to resolve their grievances under the Act.

For some years, the NMB has engaged in a systematic program of phasing out the NRAB and has continually and increasingly shifted the use of funds from its grievance resolution to its mediatory services. It proposes to continue that process into FY 90.

The NMB has deprived the members of the NRAB of office space rendering the operation of that Board much more difficult and time consuming. It has repeatedly cut the time neutral referees can spend on cases. This obviously limits the number of cases which can be heard and extends the time between hearing and decision by many months in every case. These delays are particularly injurious to employees who have been wrongfully suspended or discharged and must await the referees' decisions before they can be reinstated in their jobs.

We are told by the NMB that its grievance resolution work is decreasing and it may be decreasing in some areas to a very slight extent but it has been my experience and that of my union that the opposite is true; it is increasing. Indeed to date, the number of Signalmen grievance cases before the NMB is about 32% higher in 1989 than it was at this time in 1988.

Another difficulty the employees face is a shifting in the attitude of rail management toward the resolution of grievances. Although we have attempted to cooperate with the recommendations of the Committee on Grievance Procedures by limiting the number of cases submitted for resolution, we find that increasingly carriers insist upon rearguing cases they have lost which adds to the expense of those cases and delays justice to the employee involved, as the rearguments almost never result in reversal. And, instead of settling most grievance cases as in the past, carriers insist on pressing on to the NMB or a Special Board and when they lose, seek reargument. Such tactics thwart the objectives of the Committee's recommendations.

Another difficult and most disturbing management trend is the blackballing of referees who decide cases against management. The blackballing of referees has been practiced by both labor and management where a particular referee has a history of deciding cases for one party in cases where the legal or factual merit weighs heavily against that party; however, some carriers now exclude referees if they decide in favor of the employee even where the merit of the employee's case was clear. One result of this practice is a decline in the number of experienced and expert Railway Labor Act arbitrators available to hear and decide cases.

The basic purpose of the Railway Labor Act was and is to reduce the potential for disruption to interstate commerce by strikes. One cause of strikes is disputes arising from employee grievances. In order to remove that cause of strikes from the railroad industry the Congress designed the National Railroad Adjustment Board in its 1934 amendments to the Railway Labor Act.

While the NRAB and its supplemental boards may be the only federally financed grievance resolution procedure in this country, it must be remembered that in this country the law permits employees in other industries to strike over grievances or violations of their contracts; employees in the rail industry gave up that right for a federally financed grievance arbitration process. Rail employees must submit such disputes to a standing arbitration board - the NRAB. This has been the law in the rail industry since 1934 when the rail unions were compelled to give up their right to strike over "minor" disputes, that is, grievances and contract violations. And, when in 1957 a union took the position that the Act gave it discretion to go to the Board or to strike over its grievance, the Supreme Court rather emphatically held otherwise and based its decision upon its conviction, clearly demonstrated in the legislative history of the 1934 Act, that labor had traded its right to strike over "minor" disputes for a standing arbitration board created and maintained by the federal government. In Brotherhood of Railroad Trainmen v. Chicago River and Indiana Railroad Company, 353 U.S. 30 at 37 (1957), Chief Justice Warren, speaking for a unanimous Court said:

> The change was made with the full concurrence of the national railway labor organizations. Commissioner Joseph B. Eastman, Federal Coordinator of Transportation and principal draftsman of the 1934 bill, complimented the unions on conceding the right to strike over "minor disputes" in favor of the procedures of the Adjustment Board. (Emphasis supplied.)

Recognition of this concession of the right to strike as the quid pro quo for a federally financed compulsory arbitration board is repeated throughout the two succeeding pages of the Supreme Court's opinion in the Chicago River case.

The Congress has made a number of significant changes in the Railway Labor Act since the NRAB was created and began functioning in 1934. However, at no time has the Congress indicated that the services provided by the NRAB should be curtailed. Indeed, as demonstrated by the creation of supplemental boards in 1966, Congress intended expansion of the ability of employees to have their grievances arbitrated.

The scheme of the Railway Labor Act is very different from that of the Labor Management Relations Act because, as noted above, one of the former Act's major purpose was, and is, to reduce the occasion for strikes in the railroad industry to a minimum. It has been praised by legislators, the courts and legal scholars alike for the manner in which it has accomplished that objective - an objective which is being destroyed by the recent attitude of rail management and the NMB attempts to effectively phase out both the NRAB and the supplemental boards.

It is the view of rail labor that if NMB achieves its goal, the rationale for the Supreme Court's decision in the Chicago River case will have been removed. There will be in law no compulsory arbitration requirement on management or labor in the railroad industry because there will be no place where the parties will be able effectively to submit their grievances to be arbitrated. Since the Chicago River decision held that rail unions cannot strike because of the existence of a federally maintained arbitration board to which they must submit their "minor" disputes, it would seem quite clear that the effective absence of such a board or its ability to perform the services for which it was designed and created, enables the rail unions to strike over such disputes just as do unions in other industries. Such a result, should it occur, could plunge rail transport into chaos.

An appropriation no less than that provided last year is necessary to enable the NRAB (together with the Special Boards) to carry out its statutory functions and the objectives of the labor peace so carefully designed into the Railway Labor Act. We urgently request that appropriation be made for the use of the NRAB with a clear directive from this Committee that at least $2,120,000 of that amount be used for the employment and payment of referees. The NRAB simply must be allowed to do the job it was created to do if Congress is to keep the bargain it made with rail labor in 1934.

Thank you.

STATEMENT OF EDWARD P. MCENTEE, CHAIRMAN, RAILWAY LABOR EXECUTIVES' ASSOCIATION

My name is Edward P. McEntee. I am Vice President of the International Brotherhood of Electrical Workers and Chairman of the Railway Labor Executives' Association's Committee on Railroad Retirement. On behalf of the Railway Labor Executives' Association, I appreciate this opportunity to submit a statement in support of the appropriation request of the Railroad Retirement Board.

The Railway Labor Executives' Association is an unincorporated association with which are affiliated the chief executive officers of virtually all of the standard national and international railway labor unions in the United States. The organizations whose chief executive officers are members of the RLEA are listed below:

American Railway & Airway Supervisors Association (Division of TCU);
American Train Dispatchers Association;
Brotherhood of Locomotive Engineers;
Brotherhood of Maintenance of Way Employes;
Brotherhood of Railroad Signalmen;
Brotherhood of Railway Carmen (Division of TCU);
Hotel Employees and Restaurant Employees International Union;
International Association of Machinists and Aerospace Workers;
International Brotherhood of Boilermakers, and Blacksmiths;
International Brotherhood of Electrical Workers;
International Brotherhood of Firemen and Oilers;
International Longshoremen's Association;
National Marine Engineers' Beneficial Association;
Seafarers International Union of North America;
Sheet Metal Workers' International Association;
Transport Workers Union of America;
Transportation•Communications International Union (TCU)

We particularly support the Board's request for at least 1,600 full-time equivalent employees and whatever funds are needed to support that level of employment. Indeed, in view of the additional responsibilities imposed upon the Board by the enactment of the Railroad Unemployment Insurance and Retirement Improvement Act of 1988 and in view of the Board's ongoing initiatives to improve services through automation of its retirement claims processing operations, it is likely that additional staff resources will be needed to prevent a deterioration in current service levels. As you know, all administrative expenses of the Board are paid by the employees and management of the rail industry and, as representatives of one of the parties in the railroad industry which pays the expenses for administering the Railroad Retirement and Railroad Unemployment Insurance Acts, we urge that the Board be granted the resources required to provide the services desired and needed by its beneficiary population.

In addition to the issue of administrative funding, we would like to comment on several legislative proposals advanced as a part of the Reagan Administration's 1990 budget which would adversely affect the solvency of or the benefits paid by the Railroad Retirement system.

One of these proposals represents a renewed effort to require the Railroad Retirement trust fund to bear a portion of the costs of vested dual benefits. In past years, the Reagan Administration advanced several different schemes to achieve such a purpose. This year it resurrects the previously rejected recommendation that 25% of dual benefit costs be financed by the Railroad Retirement Account because an employee's Tier II Railroad Retirement benefit is reduced by 25% of the amount of any dual benefits he or she receives. The Administration's rationale is that the reduction in Tier II benefits due to the receipt of dual benefits produces a cost saving which is, in effect, a Federal subsidy to the trust fund. That rationale overlooks the original basis for the Tier II benefit reduction and incorrectly assumes that there is a relationship between that reduction and the obligation accepted by the Federal government in 1974 to fund the phase-out costs of dual benefits.

The reduction in the Tier II benefit of an individual who receives a vested dual benefit is merely a continuation of a reduction that was imposed under the Railroad Retirement Act of 1937 pursuant to what is called the "offset provisions". When Railroad Retirement benefit increases were provided in 1966, 1968, and 1970, it was determined that the financial condition of the Railroad Retirement system would not permit all annuitants to receive the full percentage increases which had been provided to beneficiaries under the Social Security Act. Rather than provide lesser increases for all annuitants, it was decided to reduce, or offset, the double increases which would otherwise have been paid to those receiving dual benefits. The cost savings produced by the offset provisions were retained when the Railroad Retirement Act benefit formulas were restructured in 1974 and 1981. No one could legitimately argue that those cost savings were a subsidy to the Railroad Retirement system under the 1937 Act, and the carrying forward of the savings under the 1974 Act also does not produce a subsidy to the system under any reasonable definition of that term.

To now require that the Railroad Retirement trust fund begin to bear 25% of dual benefit costs would be contrary to the understanding created in 1974 when the Federal government agreed to accept responsibility for dual benefit costs and the railroad industry agreed to accept responsibility for the costs of other benefits payable under the Railroad Retirement Act to the extent such costs exceed Social Security Act benefit levels. At that time neither the railroad industry nor the government contemplated that these other benefit costs would be increased over the levels existing under the 1937 Act. Indeed, if the offset reduction savings had been used to reduce general revenue funding at the time of the 1974 restructuring, additional financing would have to have been provided to address the added costs which would have been imposed on the Railroad Retirement trust fund. This, of course, was not done.

We also strongly object to three Administration proposals which, taken as a whole, would entirely eliminate any cost-of-living increase on Railroad Retirement Tier II benefits in 1990; would reduce those cost-of-living increases in succeeding years when inflation is high and increases are most needed; and, would also reduce other cost-of-living increases for a number of beneficiaries in all future years.

In recent years, Railroad Retirement beneficiaries have experienced the elimination and reduction of cost-of-living increases because of the enactment of the Railroad Retirement

Solvency Act of 1983. These sacrifices and other major benefit adjustments were accepted by the beneficiaries as necessary to insure the solvency of the Railroad Retirement system and were made only after thoughtful consideration balancing the needs of beneficiaries against the financial needs of the system. No comparable consideration supports the current proposals. In fact, the Railroad Retirement Board's most recent actuarial valuation did not recommend that any action was needed to improve the Retirement system's financial condition.

In our view, there is no basis in justice, equity or reason to require our beneficiaries to suffer benefit reductions for reasons unrelated to the trust funds out of which their benefits are paid. The Railroad Retirement trust funds are able to support the benefits provided by current law, and we consider it totally objectionable to propose reducing those benefits in order to offset Federal deficits in other areas. In 1986, Gramm-Rudman was amended for the express purpose of preventing the elimination or reduction of Tier II benefit increases for the purpose of reducing the Federal deficit. We urge that the Administration's current reduction proposals be summarily rejected.

In addition to the foregoing, I would like to briefly comment on one other area that has become a matter of concern to rail labor. As you know, although the Railroad Retirement Board administers the benefit payment provisions of the Railroad Retirement Act, the Board has no authority over the provisions of the Railroad Retirement Tax Act which provides the funds needed to pay those benefits. The Tax Act is administered by the Internal Revenue Service, and in recent years the Board has experienced difficulty in obtaining information from the IRS needed to insure that tax deposits are credited both timely and accurately to the different Railroad Retirement trust funds. Difficulties have also been encountered in coordinating opinions concerning the creditability of service and compensation and in assuring that the same standards are applied in making such determinations for both benefit and taxation purposes. In order to eliminate such inefficiencies and inconsistencies, and to improve the integrity of the Railroad Retirement system as a whole, we believe consideration should be given to transferring responsibility for the administration of the Tax Act to the Railroad Retirement Board.

Mr. Chairman, this Committee has always been fair to railroad retirees and sensitive to their welfare. It has always shown compassion. Railroad retirees are grateful for the efforts of this Committee. We ask again for your understanding and help on these important issues.

Thank you.

STATEMENT OF THOMAS C. WESTROPP, CHAIR OF THE BOARD, THE NATIONAL PEACE INSTITUTE FOUNDATION

Mr. Chairman, Members of the Committee, my name is Thomas C. Westropp, and I am the Chairman of the Board of the National Peace Institute Foundation and former Treasurer of the National Peace Academy Campaign. The Foundation grew out of the National Peace Academy Campaign, which was instrumental in the creation of the United States Institute of Peace.

The Foundation is not officially affiliated with the United States Institute of Peace. We are an independent organization with approximately 14,000 members who financially support our activities, and a group of close to 50,000 interested citizens who worked along with Congress to create the Peace Institute in the years leading up to its establishment. We therefore retain the keenest possible interest in the Institute and its continuing growth.

This testimony has two purposes. The first is to urge the Committee to appropriate the full $9.45 million requested by the Institute for Fiscal Year 1990. The second is to pay tribute to this Committee, to the Senate as a whole and to the Congress generally for inspiring a new generation of scholars to put their minds to work, and re-inspiring diplomats and other practitioners of international conflict resolution to put their experience to work, in developing new theories, processes, and techniques for waging peace.

The two purposes are directly connected. In the last three years -- a period in which the U. S. Institute of Peace has been operating strongly thanks to Congressional steadfastness on appropriations -- the number of courses in peace studies and conflict resolution in American universities and colleges has doubled. Some two hundred colleges and universities now offer courses in what is sometimes referred to as a "new science" of conflict resolution. Thirty-six universities offer a Masters degree and twelve have Ph.D. programs in peace and conflict resolution studies. Perhaps these trends will gradually help to redress a serious historic and current imbalance: While the number of professionals engaged in research and development of processes for producing peace can be counted in the dozens, an estimated half-million scientists are employed today in weapons research and other projects related to waging war.

In any case, it is very clear to those of us who follow the work of the Institute that, in creating this federally-funded institution, Congress also ignited the interest of the academic community.

It is also clear that the Institute's Jennings Randolph Fellowship Program is providing a very important system and forum for professional diplomats and other experienced international practitioners to share their valuable experience with their peers, with other scholars, and with the public. This insures that lessons learned from past conflicts can be guideposts for policymakers in dealing with contemporary situations of continuing strife. We understand why Senator Randolph is so proud to have this program named for him.

Thus in the international community of professional peacemakers, and in smaller and larger, public and private institutions of higher education across our country, the conviction has fortunately taken hold that the government of the

United States, and particularly the Congress, has a strong commitment to support peace research and conflict resolution studies. It is becoming recognized that this commitment to the U. S. Institute of Peace is just as important as is the government's commitment to support the arts and humanities through National Endowments devoted to these fields and to biomedical research through the National Institute of Health.

To make a different kind of comparison, the Committee will remember that the hope of the tens of thousands of persons involved in the National Peace Academy Campaign was that Congress would create an institution to be the equivalent of the military service academies, with a campus and degree-granting programs. The institution we have is quite different and may in the end serve us equally well if it is supported in the same consistent, substantial fashion as the service academies.

I call the Committee's attention to the fact that, according to our information, the 1989 appropriations for the Army, Navy, and Air Force Academies totaled approximately $600 million, and I assume the figure will be higher for 1990. Compare with that figure the request of the U. S. Institute of Peace for 1990 -- less than its authorized level of $10 million -- and it becomes patently clear that this request is an extremely modest one.

Our members strongly believe that an appropriation for the U. S. Institute of Peace -- which amounts to less than four cents per American citizen -- is a small investment in this enterprise of central importance to our common future.

The Board of Directors of the Foundation will be working to insure that the Institute's appropriation continues to grow in years to come, and is not limited for long by the $10 million ceiling Congress placed on the authorization for the Institute through FY 91 and the $15 million through FY 1993. The Institute's track record, specific additional needs, and growing public interest in conflict resolution as an instrument for peacebuilding, together justify a much larger national investment in the enterprise, even if that investment is made only gradually, in steady increments.

We take heart from the Committee's strong support in earlier years. We are further heartened when we see additional individual Senators join that original cadre of staunch supporters -- Senator Matsunaga, Senator Hatfield, Senator Randolph, and Chairman Harkin -- in manifesting strong personal interest in the future of the Institute, directly, or through the National Peace Institute Foundation. In this regard, my Board is deeply pleased that Senator Paul Simon and former Senator Robert Stafford have joined our Advisory Board as a way of endorsing our mission and work, hence that of the Institute.

The Foundation, like the Institute, realizes that these are particularly difficult fiscal times for the nation, and that this year will represent an extremely difficult budgetary challenge for the Committee and the Congress. Nonetheless, we should all remember that in the mandate for the Institute set forth by the Congress in 1984, it was that the Institute be "a living institution embodying the heritage, ideals and concerns of the American people for peace."

We hope the Committee agrees with us that the only possible way for the Institute to fulfill that mandate is through adequate appropriations. Hence we hope the requested $9.45 million will be approved.

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